



Optum Specialty Phone: 855-427-4682  
Optum Specialty Fax: 877-342-4596

# Immune Globulin Therapy Enrollment Form

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here.

This form is not a valid prescription in Arizona

## PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name \_\_\_\_\_  
Address \_\_\_\_\_  
Address 2 \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_  
DOB \_\_\_\_\_ Last Four of SS# \_\_\_\_\_ Gender \_\_\_\_\_  
Language Preference:  English  Spanish  Other \_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber's Name \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Group/Hospital \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

## INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number \_\_\_\_\_

## MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis — Please include diagnosis name with ICD-10 code

D80.0 Hereditary hypogammaglobulinemia  
 D80.1 Nonfamilial hypogammaglobulinemia  
 D80.3 Selective deficiency of immunoglobulin G [IgG] subclasses  
 D83.8 Other common variable immunodeficiencies  
 D83.9 Common variable immunodeficiency, unspecified  
 G61.81 Chronic inflammatory demyelinating polyneuropathy  
 G61.9 Inflammatory polyneuropathy, unspecified  
 Other Diagnosis: ICD-10 Code \_\_\_\_\_  
Description \_\_\_\_\_  
Date of Diagnosis \_\_\_\_\_  
Start Date \_\_\_\_\_ Review Date \_\_\_\_\_ Next Infusion Date \_\_\_\_\_

Additional Information Therapy:  New  Reauthorization  Restart

Weight \_\_\_\_\_ kg/lbs Height \_\_\_\_\_ cm/in  
Allergies \_\_\_\_\_  
Lab Data \_\_\_\_\_  
Concomitant Medications \_\_\_\_\_  
Additional Comments \_\_\_\_\_

## PRESCRIPTION INFORMATION

Medication	Route	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> Bivigam <input type="checkbox"/> Carimune-NF <input type="checkbox"/> Cuvitru <input type="checkbox"/> Flebogamma 5% <input type="checkbox"/> Flebogamma 10% <input type="checkbox"/> Gamastan S/D <input type="checkbox"/> Gammagard <input type="checkbox"/> Gammagard S/D <input type="checkbox"/> Gammaked <input type="checkbox"/> Gammaplex <input type="checkbox"/> Gamunex-C <input type="checkbox"/> Hizentra <input type="checkbox"/> HyperRHO S/D <input type="checkbox"/> HyQvia <input type="checkbox"/> Octagam <input type="checkbox"/> Privigen <input type="checkbox"/> Rhophylac <input type="checkbox"/> WinRho SDF <input type="checkbox"/> Other: _____	<input type="checkbox"/> SC <input type="checkbox"/> IV <input type="checkbox"/> IM			<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other _____	
<b>Pre-medication / Prophylaxis Regimen</b>					
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> PO	<input type="checkbox"/> 500 mg <input type="checkbox"/> 1 g <input type="checkbox"/> Other _____		<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other _____	
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> PO <input type="checkbox"/> IV	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> Other _____		<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other _____	
<input type="checkbox"/> EMLA Cream					
<input type="checkbox"/> Epi-Pen					
<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> PO	<input type="checkbox"/> 200 mg <input type="checkbox"/> Other _____		<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other _____	
<input type="checkbox"/> Normal Saline	<input type="checkbox"/> IV			<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other _____	
<input type="checkbox"/> Other: _____					

For Home Infusion Services, please contact Optum Infusion Pharmacy: Phone: 877-342-9352 Fax: 888-594-4844

Ship to:  Patient  Office  Other \_\_\_\_\_ Date \_\_\_\_\_ Needs by Date \_\_\_\_\_

\*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Product Substitution permitted  Dispense as Written

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_ Supervising Physician Signature: \_\_\_\_\_ Date \_\_\_\_\_

Electronic or digital signatures not accepted.

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona.