

Patient Name _____ SS# _____ DOB _____ ☐ Male ☐ Female
 Street Address _____ Apt# _____ City _____ State _____ Zip _____
 Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
 Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office Local Pharmacy Phone _____
 Allergies _____ Comorbidities _____
 Current Medications (if necessary, please fax a complete list) _____

Practice Name _____ Primary Contact _____ Tel _____
 Prescriber _____ NPI # _____
 Practice Address _____ Suite# _____ City _____ State _____ Zip _____

Insured's Name _____ Relation to Patient _____
 Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____ Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
 Tel _____ Fax _____ Policy/Group# _____
 Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

ICD-10 Code

- | | |
|---|--|
| <input type="checkbox"/> D80.0 Hereditary Hypogammaglobulinemia | <input type="checkbox"/> D81.89 Other Combined Immunodeficiencies |
| <input type="checkbox"/> D80.5 Immunodeficiency with Increased immunoglobulin M (IgM) | <input type="checkbox"/> D81.9 Combined Immunodeficiency, Unspecified |
| <input type="checkbox"/> D81.0 Severe Combined Immunodeficiency with Reticular Dysgenesis | <input type="checkbox"/> D82.0 Wiskott-Aldrich Syndrome |
| <input type="checkbox"/> D81.1 Immunodeficiency with Low T- and B-Cell Numbers | <input type="checkbox"/> D83.0 CVID with Predom Abnl of B-Cells numbers and functions |
| <input type="checkbox"/> D81.2 Severe Combined Immunodeficiency with Low or Normal T- and B-Cell Numbers | <input type="checkbox"/> D83.2 CVID with Autoantibodies to B- or T-Cells |
| <input type="checkbox"/> D81.6 Major Histocompatibility Complex Class 1 Deficiency | <input type="checkbox"/> D83.8 Other Common Variables |
| <input type="checkbox"/> D81.7 Major Histocompatibility Complex Class 2 Deficiency | <input type="checkbox"/> D83.9 Common Variable Immunodeficiency, Unspecified |

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PHYSICIAN ORDERS – SCIg THERAPY (Pharmacy to provide pump and necessary supplies for administration of SCIg)

Infuse Immune Globulin ☐ 10% OR ☐ 20% _____ Gms into _____ (#) of subcutaneous sites simultaneously via pump over _____ hours
 Infusion Frequency: _____ Quantity: _____ # of Refills: _____
 Brand: _____

PRE-MED ORDERS

Apply topically to skin 30 minutes prior to subcutaneous needle insertion.

- ☐ Emla 2.5% Cream
☐ LMX -4 Cream
☐ Other Medications: _____

ANAPHYLAXIS ORDERS

Anaphylaxis Kit: ☐ Adult EpiPen 0.3mg/0.3mL Auto-Injector
☐ Pediatric EpiPen Jr. 0.15mg/0.3mL Auto-Injector

NURSING ORDERS

- ☐ Provide skilled nursing care to instruct administration of SCIg therapy.
☐ Nurse to complete physical assessment including vital signs with each visit.
☐ Provide education regarding medication, disease state, adverse drug reactions and procedures, pump and pump care, & administration.
☐ Observe for response to therapy.
☐ Patient to be discharged from nursing once independent with therapy administration.

COMMENTS

By signing this form and utilizing our services, you are authorizing BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies where allowed by law or contract.

Prescriber's Signature _____ Dispense as written (signature required. NO STAMPS) OR Product Substitution Permitted (signature required. NO STAMPS) **Date** _____

Prescriber's Email _____

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to BioMatrix Specialty Pharmacy or any of its subsidiaries using the contact information provided on this cover sheet. RFO13-NIT_3 02/19

Please visit **WWW.BIOMATRIXSPRX.COM** for more information