briovaRx®

Fax:

Phone:

Immune Globulin Therapy Enrollment Form

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 polyneuritis

☐ 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
☐ Bivigam ☐ Carimune-NF ☐ Cuvitru ☐ Flebogamma 5% ☐ Flebogamma 10% ☐ Gamastan S/D ☐ Gammagard ☐ Gammagard S/D ☐ Gammaked ☐ Gammaplex ☐ Gamunex-C ☐ Hizentra ☐ HyperRHO S/D ☐ HyQvia ☐ Octagam ☐ Privigen ☐ Rhophylac ☐ WinRho SDF ☐ Other: _____	☐ SC ☐ IV ☐ IM			☐ 1 month ☐ 3 months ☐ Other _____	
Pre-medication/Prophylaxis Regimen					
☐ Acetaminophen	☐ PO	☐ 500 mg ☐ 1 g ☐ Other _____		☐ 1 month ☐ 3 months ☐ Other _____	
☐ Diphenhydramine	☐ PO ☐ IV	☐ 25 mg ☐ 50 mg ☐ Other _____		☐ 1 month ☐ 3 months ☐ Other _____	
☐ EMLA Cream					
☐ Epi-Pen					
☐ Ibuprofen	☐ PO	☐ 200 mg ☐ Other _____		☐ 1 month ☐ 3 months ☐ Other _____	
☐ Normal Saline	☐ IV			☐ 1 month ☐ 3 months ☐ Other _____	
☐ Other: _____					

***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.

Ship to: ☐ Patient ☐ Office ☐ Other _____ Date _____ Needs by Date _____

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature _____ Date _____