Upstate HomeCare

The Best for Getting Better

Ig Therapy Enrollment Form

Phone: (888) 648-2211 Fax: (315) 580-4297

Complete or Attach Patient's Demographic Information

Patient Name: _____ Gender: ☐ M ☐ F DOB: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone: _____ Alternate Phone: _____

Alternate Caregiver / Emergency Contact: _____ Contact Phone: _____

Complete or Attach Patients's Insurance Information

Primary Insurance: _____ ID#: _____ Insurance Phone: _____

Secondary Insurance: _____ ID#: _____ Insurance Phone: _____

RX Carrier Name: _____ RX ID#: _____ RX Group#: _____ RX Phone: _____

Complete Diagnostic/Clinical Information - FAX Clinical Notes, Labs, Test Results

Current History of: ☐ Renal Dysfunction ☐ HTN ☐ Thromboembolic Event ☐ CHF ☐ Diabetes

☐ Other: _____

Previous IG Therapy: ☐ No ☐ Yes If Yes: Date: _____ Dose: _____ Last Received: _____

Allergies: _____ Height: _____ Weight: _____

Complete Prescription Information OR E-Scribe: Upstate HomeCare

ICD10 Code/Diagnosis:

☐ D69.3	Idiopathic Thrombocytopenic Purpura (ITP)	☐ G60.3	Idiopathic Progressive Neuropathy
☐ D80.1	Hypogammaglobulinemia	☐ G61.0	Guillain-Barre Syndrome
☐ D80.3	Other Selective Immunoglobulin Deficiency	☐ G61.81	Chronic Inflammatory Demyelinating Polyneuritis
☐ D80.4	Selective IgM Deficiency	☐ G61.9	Multifocal Motor Neuropathy
☐ D81.0	Severe Combined Immunodeficiency (SCID)	☐ G70.00	Myasthenia Gravis
☐ D81.9	Combined Immunodeficiency, unspecified	☐ G70.01	Myasthenia Gravis, with Acute Exacerbation
☐ D82.0	Wiskott-Aldrich Syndrome	☐ L10.9	Pemphigus
☐ D83.8	Other Common Variable Immunodeficiencies	☐ L12.0	Pemphigoid
☐ D83.9	Common Variable Immunodeficiency (CVID)	☐ M30.3	Kawasaki Syndrome
☐ G25.82	Stiff-Man Syndrome	☐ M33.20	Polymyositis, Organ Involvement
☐ G35	Multiple Sclerosis- Relapsing- Remitting	☐ M33.90	Dermatopolymyositis, Organ Involvement
		☐ Other:	_____

IG Drug: _____ Dose: _____ Frequency: _____ # of Refills: _____

Administration Rate: ☐ Per Upstate HomeCare Guidelines, as tolerated ☐ Per Manufacturer Guidelines, as tolerated

Other: _____

☐ Dispense as Written ☐ Substitution Permissible

Complete Prescriber Information

Provider Name: _____ Provider Phone: _____

Key Contact: _____ Alternate Phone: _____

Signature: **Date:**