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: ______

Complete or Attach Patient'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:

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

Ig Drug: ______ Dose: ______ Frequency: ______ # of Refills: ______
Administration Rate: ☐ Per Upstate HomeCare Guidelines, as tolerated ☐ Per Manufacturer Guidelines, as tolerated-
☐ Sodium Chloride 10mL Flushes (Use as directed #3 with 11 refills) Other: ______
☐ Dispense as Written ☐ Substitution Permissible

Anaphylactic Orders:

☐ Epinephrine 1mg/mL Vial #1 (Use in the event of an anaphylactic reaction. Adult dose = 0.3mL IV/intramuscularly)
☐ Benadryl 50mg/mL Vial #1 (Use IV/intramuscularly in the event of an anaphylactic reaction.
☐ Sodium Cl 0.9% 250mL Bag #1 (Use in the event of an anaphylactic reaction.)

Complete Prescriber Information

Provider Name: ______ Provider Phone: ______
Key Contact: ______ Alternate Phone: ______

Signature: ______ **Date:** ______

By signing this form, you, as the following physician are authorizing an Upstate HomeCare Pharmacist to transcribe the above order into verbal orders.

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligate to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. IMPORTANT WARNING: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.