IVIG ENROLLMENT FORM

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ALTHEA
INFUSION & SPECIALTY PHARMACY™

★ Patient Name: _____ DOB: / / Height: _____ ★Weight: _____kg Date: / /

Allergies: _____ Email: _____

Address: _____ Ph: _____

★ Prescriber: _____ Ph: _____ Fax: _____

Ship to: ☐ Patient ☐ MD Office ☐ Althea Location:

★ Prescriber Signature _____

DOCUMENTS TO INCLUDE WITH REFERRAL

- ★ • Patient demographics
- ★ • Copies of insurance card (front and back)
- ★ • Pharmacy Card
- ★ • **Recent Lab Results**: CBC with differential, Quantitative immunoglobulins (IgG, IgA, IgM), Antibody titers (e.g., pneumococcal, tetanus), Hepatitis B & C panel, TB screening (Quantiferon or TST), HIV screening
- ★ • Specialist consults and recent progress notes
- • Prior medications and therapies (failed or inadequate response)
- • Relevant imaging studies (MRI, CT, X-ray, etc.)
- • Baseline functional assessment with detailed symptom history

DIAGNOSIS

- ☐ D83.0 – Common Variable Immunodeficiency (CVID) D80.3 – Selective Deficiency of IgG
- ☐ D75.82 – Immune Thrombocytopenia (ITP)
- ☐ G61.81 – CIDP
- ☐ G70.01 – Myasthenia Gravis
- ☐ G35 – Multiple Sclerosis (RRMS)
- ☐ G61.0 – Guillain-Barré Syndrome
- ☐ G61.82 – Multifocal Motor Neuropathy (MMN) G25.82 – Stiff-Person Syndrome
- ☐ L10.0 – Pemphigus Vulgaris
- ☐ D69.3 – Immune Thrombocytopenic Purpura (ITP)
- ☐ Other: _____

IVIG PRESCRIPTION — DOSAGE AND ADMINISTRATION

☐ **Alyglo® (immune globulin IV)**	☐ Alyglo 5 g / 50 mL ☐ Alyglo 10 g / 100 mL ☐ Alyglo 20 g / 200 mL	Dose: _____ g/kg Frequency: _____
☐ **Asceniv™ (immune globulin IV)**	☐ Asceniv 1 g/vial	Dose: _____ g/kg Frequency: _____
☐ **Bivigam® (immune globulin IV)**	☐ Bivigam 1 g/vial	Dose: _____ g/kg Frequency: _____
☐ **Gammagard® (immune globulin IV/SC)**	☐ Gammagard 1 g / 10 mL	Dose: _____ g/kg Frequency: _____
☐ **Gamunex®-C (immune globulin IV/SC)**	☐ Gamunex-C 10% ☐ Gamunex-C 10% 1 g / 10 mL vial	Dose: _____ g/kg Frequency: _____
☐ **Gammaked™ (immune globulin IV/SC)**	☐ Gammaked 10% 5 g / 50 mL	Dose: _____ g/kg Frequency: _____
☐ **Octagam® (immune globulin IV)**	☐ Octagam 5% 1 g / 20 mL ☐ Octagam 10% 2 g / 20 mL	Dose: _____ g/kg Frequency: _____
☐ **Panzyga® (immune globulin IV)**	☐ Panzyga 10% 2.5 g / 25 mL vial	Dose: _____ g/kg Frequency: _____
☐ **Privigen® (immune globulin IV)**	☐ Privigen 10% 5 g vial	Dose: _____ g/kg Frequency: _____

SCIG PRESCRIPTION — DOSAGE AND ADMINISTRATION

☐ **Cutaquig® (immune globulin SC)**	☐ Cutaquig 16.5% 1 g / 6 mL (OCT) ☐ Cutaquig 1 g / 6 mL vial (Pfz)	Dose: _____ g/kg Frequency: _____
☐ **Hizentra® (immune globulin SC)**	☐ Hizentra 20% 1 g syringe / 5 mL	Dose: _____ g/kg Frequency: _____
☐ **HyQvia® (immune globulin SC)**	☐ HyQvia SubQ Kit 2.5 g / 25 mL	Dose: _____ g/kg Frequency: _____
☐ **Xembify® (immune globulin SC)**	☐ Xembify 20% 1 g vial / 5 mL	Dose: _____ g/kg Frequency: _____
☐ **Nabi-HB® (hepatitis B immune globulin)**	☐ Nabi-HB 5% / 5 mL SDV	Dose: _____ g/kg Frequency: _____

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol - Flushing per S.A.S.H. protocol (Saline, Administer medication, Saline, Heparin) specific volumes and concentrations based on patient's line type.

Premedications & Other Medications - Infusion supplies as per protocol. Anaphylaxis Kit orders as per protocol.

☐ Acetaminophen ☐ mg PO prior to infusion ☐ Diphenhydramine ☐ mg PO

☐ Methylprednisolone ☐ Other: _____