BLUEGRASS PHARMACY | IMMUNE GLOBULIN (IG) ENROLLMENT FORM

BLUEGRASS Pharmacy
A Member of the Wellpartner Family

FAX FORM TO: 1.866.233.8317 | **PHONE:** 1.855.492.0817 | **EMAIL:** contact@bluegrass-rx.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:
Address:
City, State, ZIP:
Primary Phone: - - DOB: / /
Alternate Phone: - - Gender:
Email:
Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:
DEA #: NPI #: State Lic. #:
Group or Hospital:
Address:
City, State, Zip:
Phone: - - Fax: - -
Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:
Primary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

Secondary Insurance Company Name:
Secondary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:

◯ Primary immune deficiency (please state specific condition and ICD-10 code): _____
◯ C91.9Ø Lymphoid leukemia, unspecified
◯ D8Ø.Ø Hereditary hypogammaglobulinemia
◯ D83.9 Common variable immunodeficiency, unspecified
◯ D84.9 Immunodeficiency, unspecified
◯ D69.3 Immune thrombocytopenic purpura
◯ G61.81 Chronic inflammatory demyelinating polyneuritis
◯ M3Ø.3 Mucocutaneous lymph node syndrome [Kawasaki]
◯ Other:

Did patient previously receive IG? ◯ Yes ◯ No Date of Diagnosis: / /
Previous products received:
◯ Diabetes ◯ CHF ◯ Renal failure/renal insufficiency
Height (in/cm): Weight (lb/kg):
Other pertinent history:
Nursing needed? ◯ Yes ◯ No ◯ TBD Agency of choice: _____
If no, reason: ◯ Trained to self-administer ◯ MD office to administer ◯ Home health nursing coordinated
Allergies:
Current Medications:

5. PRESCRIPTION INFORMATION

Medication	Route	Dose/Strength	Directions	Quantity	Refills
◯ Acetaminophen	◯ PO	◯ 500 mg ◯ 1 gram ◯ Other:	◯ Pre-med ◯ Other:	◯ 1 month ◯ 3 months ◯	◯ 1 year
◯ Diphenhydramine	◯ PO ◯ IV	◯ 25 mg ◯ 50 mg	◯ Pre-med ◯ PRN allergic reaction ◯ Other:.	◯ 3 months ◯	◯ 1 year
◯ Epinephrine	◯ IM	◯ Adult 1:1000, 0.3 ml (>30 kg/66 lb) ◯ Pedatric 1:2000, 0.3 ml (≥15-30 kg/33-66 lb)	◯ PRN prophylaxis ◯ Other:	◯ 1 month ◯ 3 months ◯	◯ 1 year
◯ Immune Globulin	◯ SC ◯ IM ◯ IV	_____ grams _____ mg/kg		◯ 1 month ◯ 3 months	◯ 1 year
◯ Normal Saline ◯ Heparin 10 units/ml ◯ Heparin 100 units/ml ◯ D5W	◯ IV	_____ _____ _____ _____	◯ Use as needed to maintain IV access and patency ◯ Other:	◯ 1 month ◯ 3 months ◯	
◯ Other:					

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /
DISPENSE AS WRITTEN DATE

X / /
PRODUCT SUBSTITUTION PERMITTED DATE