vitalcare® of MERIDIAN

Immune Globulin Enrollment Form
Phone: (601) 482-4003 | Fax: (601) 482-3948

Demographics

Patient Name:_____
Address:_____
City:_____State:_____Zip:_____
DOB:___/___/___/ ☐ Male ☐ Female
Phone:_____ 2nd Phone:_____
SSN:_____ Ht:_____Wt:_____

Insurance Information *(Attach copy of cards, if available)*

Primary Insurance

Member#:_____Group #:_____
Policy Holder:_____Relation:_____

Secondary Insurance

Member #:_____Group #: _____
Policy Holder:_____Relation: _____

Physician's Orders *(Please check the following)*

☐ Ig Therapy Dose_____grams/kg/day x _____days
or _____grams/day x _____days

Interval (*freq. of therapy*):_____# of refills: _____

Ig Product: _____ ☐ *Do Not Substitute.*

Route of Admission: ☐ SubQ ☐ IV ☐ IM

☐ Benadryl 25 to 50 mg PO _____
☐ Benadryl 25 to 50 mg IV _____
☐ Tylenol 650 or 1000 mg PO _____ IV
☐ Steriods: _____ Dose: _____ Pre/Post IV
☐ Hydration: _____ Pre/Post
☐ *Anaphylaxis Kit per protocol*
☐ 0.9% sodium chloride 5 to 10mL pre/post infusion and PRN
☐ Heparin 100 units/mL 5mL post infusion and PRN
☐ Heparin 10 units/mL 5mL post infusion and PRN
☐ Skilled Nursing visits as required
☐ Standard supplies as needed
☐ First dose to be given in home

Has the patient received Ig previously? Yes☐ No☐
Date of Last Dose: _____ Product: _____
Allergies: _____ Route: _____
Anticipated Start Date: _____

Diagnosis

☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
☐ Myasthenia Gravis **without acute exac.**
☐ Myasthenia Gravis **with acute exac.**
☐ Multiple Sclerosis
☐ Polyneuropathy Idiopathic, **Progressive**
☐ Guillian-Barre Syndrome (acute infective polyneuritis)
☐ Multifocal Motor Neuropathy
☐ Common Variable Immune Deficiency (CVID)
IgG Level: _____Date: _____
☐ Hypogammaglobulinemia
IgG Level: _____Date: _____
☐ Congenital Hypogammaglobulinemia
☐ Immunodeficiency with increased IgM
☐ Wiskott-Aldrich Syndrome
☐ Combined Immunity Deficiency
☐ Other: _____
ICD-10 Code, if applicable: _____

Prescribing Physician

Name:_____

Address: (please include facility name)

Phone:_____Fax:_____

Specialty:_____

License#:_____UPIN#:_____

DEA:_____NPI:_____

Signature:_____

Date:_____

Fax complete copies of the following to Vital Care RX @ (877)229-1725: (1) Referral Form and (2) Insurance Card(s).