



Optum Specialty Phone: 855-427-4682
Optum Specialty Fax: 877-342-4596

Immune Globulin Therapy Enrollment Form

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here.

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name _____
Address _____
Address 2 _____
City, State, ZIP _____
Home Phone _____ Alternate Phone _____
DOB _____ Last Four of SS# _____ Gender _____
Language Preference: English Spanish Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____
DEA _____
NPI _____
Group/Hospital _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____
Contact Person _____ Phone _____

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number _____

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis — Please include diagnosis name with ICD-10 code

D80.0 Hereditary hypogammaglobulinemia
 D80.1 Nonfamilial hypogammaglobulinemia
 D80.3 Selective deficiency of immunoglobulin G [IgG] subclasses
 D83.8 Other common variable immunodeficiencies
 D83.9 Common variable immunodeficiency, unspecified
 G61.81 Chronic inflammatory demyelinating polyneuropathy
 G61.9 Inflammatory polyneuropathy, unspecified
 Other Diagnosis: ICD-10 Code _____
Description _____
Date of Diagnosis _____
Start Date _____ Review Date _____ Next Infusion Date _____

Additional Information Therapy: New Reauthorization Restart

Weight _____ kg/lbs Height _____ cm/in
Allergies _____
Lab Data _____
Concomitant Medications _____
Additional Comments _____

PRESCRIPTION INFORMATION

Medication	Route	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> Bivigam <input type="checkbox"/> Carimune-NF <input type="checkbox"/> Cuvitru <input type="checkbox"/> Flebogamma 5% <input type="checkbox"/> Flebogamma 10% <input type="checkbox"/> Gamastan S/D <input type="checkbox"/> Gammagard <input type="checkbox"/> Gammagard S/D <input type="checkbox"/> Gammaked <input type="checkbox"/> Gammaplex <input type="checkbox"/> Gamunex-C <input type="checkbox"/> Hizentra <input type="checkbox"/> HyperRHO S/D <input type="checkbox"/> HyQvia <input type="checkbox"/> Octagam <input type="checkbox"/> Privigen <input type="checkbox"/> Rhophylac <input type="checkbox"/> WinRho SDF <input type="checkbox"/> Other: _____	<input type="checkbox"/> SC <input type="checkbox"/> IV <input type="checkbox"/> IM			<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other _____	
Pre-medication / Prophylaxis Regimen					
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> PO	<input type="checkbox"/> 500 mg <input type="checkbox"/> 1 g <input type="checkbox"/> Other _____		<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other _____	
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> PO <input type="checkbox"/> IV	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> Other _____		<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other _____	
<input type="checkbox"/> EMLA Cream					
<input type="checkbox"/> Epi-Pen					
<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> PO	<input type="checkbox"/> 200 mg <input type="checkbox"/> Other _____		<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other _____	
<input type="checkbox"/> Normal Saline	<input type="checkbox"/> IV			<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other _____	
<input type="checkbox"/> Other: _____					

For Home Infusion Services, please contact Optum Infusion Pharmacy: Phone: 877-342-9352 Fax: 888-594-4844

Ship to: Patient Office Other _____ Date _____ Needs by Date _____

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Product Substitution permitted Dispense as Written

Prescriber's Signature _____ Date _____ Supervising Physician Signature: _____ Date _____

Electronic or digital signatures not accepted.

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona.