SMP PHARMACY SOLUTIONS

Fax#: 855-447-6637
Ph#: 855-650-5009

Immune Globulin Prescription Faxable

Today's Date: _____ **Needed by:** _____ **Name:** _____ **Phone:** _____

Patient Demographic: (Provide the following or attached demographic sheet)

Patient Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Alt. Phone: _____

SS#: _____ Date Birth: _____

Gender: _____ Height: _____ Weight_____ BSA ____ m2

Prescriber: (Provide as much information as possible)

Prescriber's Name: _____ Group/Hospital: _____

Specialty: _____ NPI #: _____ DEA: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Alt. Contact Name: _____

Phone: _____ Position: _____

Insurance Information (Please copy and attach the front and back of the Insurance Card):

Primary Insurance Name: _____ ID# _____ BIN#: _____ Group#: _____ PCN#: _____ Phone: _____

☐ No Insurance ☐ Patient will pay out of pocket ☐ Enroll in Manufacturer's Patient Assistance Program

Medication Delivery to (Choose Only One):

☐ Patient Address ☐ First Fill Physician's Office, Refill to Patient Address ☐ Patient will pick up at Pharmacy

Diagnosis (ICD-10 code): ☐ G61.8 CIDP (Chronic Inflammatory Demyelinating Polyneuropathy) ☐ D84.9 PI (Primacy Humoral Immunodeficiency) ☐ D69.3 Chronic ITP (Chronic Immune Thrombocytopenic Purpura) ☐ G62.8 MMN (Multifocal Motor Neuropathy)

☐ Other _____

Infusion Location: ☐ Home Infusion ☐ Office Infusion ☐ Infusion Center ☐ Other

Patient Allergies/ Allergic Reactions:

1. _____ 2. _____

Prior (Failed) Medications (Reason for D/C):

1. _____ 2. _____

Medication	Route	Direction	Quantity	Refills
☐ **BIVGAM®**	**IV**	**SIG:**		
☐ **Carimune®**	**IV**	**SIG:**		
☐ **Flebogamma® (5% or 10%)**	**IV**	**SIG:**		
☐ **Gammagard® (5% or 10%)**	**IV/SC**	**SIG:**		
☐ **Gammaked®**	**IV/SC**	**SIG:**		
☐ **Gammaplex®**	**IV**	**SIG:**		
☐ **Gamunex-C®**	**IV/SC**	**SIG:**		
☐ **Hizentra®**	**SC**	**SIG:**		
☐ **Octagam® (5% or 10%)**	**IV**	**SIG:**		
☐ **Privigen®**	**IV**	**SIG:**		
☐ **Other**		**SIG:**		

☐ Sharps Package: (Sterile sponges, alcohol swabs, sharps container)

By signing this form and utilizing our services, you are authorizing SMP and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

_____ _____/_____/_____

Prescriber Signature Date