Optum

# Immune Globulin Therapy Enrollment Form

Optum Specialty Phone: 877-445-6874 | Optum Specialty Fax: 866-306-5231

**Specialty Pharmacy Enrollment Form**

Please detach before submitting to a pharmacy – tear here

**This form is not a valid prescription in Arizona or Virginia**

## 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 polyneuritis

☐ 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 |
|---|---|---|---|---|---|
| ☐ Gamastan ☐ Micrhogam<br>☐ Gammagard ☐ Octagam<br>☐ Gammagard S/D ☐ Privigen<br>☐ Gammaplex ☐ Rhogam Plus<br>☐ Hizentra ☐ WinRho SDF<br>☐ HyperRHO S/D ☐ Other: _____<br>☐ HyQvia | ☐ SC ☐ IV<br>☐ IM | | | ☐ 1 month ☐ 3 months<br>☐ Other _____ | |
| **Pre-medication/Prophylaxis Regimen** | | | | | |
| ☐ Acetaminophen | ☐ PO | ☐ 500 mg ☐ 1 g<br>☐ Other _____ | | ☐ 1 month ☐ 3 months<br>☐ Other _____ | |
| ☐ Diphenhydramine | ☐ PO ☐ IV | ☐ 25 mg ☐ 50 mg<br>☐ Other _____ | | ☐ 1 month ☐ 3 months<br>☐ Other _____ | |
| ☐ EMLA Cream | | | | | |
| ☐ Epi-Pen | | | | | |
| ☐ Ibuprofen | ☐ PO | ☐ 200 mg<br>☐ Other _____ | | ☐ 1 month ☐ 3 months<br>☐ Other _____ | |
| ☐ Normal Saline | ☐ IV | | | ☐ 1 month ☐ 3 months<br>☐ Other _____ | |
| ☐ Other: _____ | | | | | |

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

* Prescriber Authorization: "I authorize this pharmacy and its representatives to act as my authorized agent, including but not limited to, attestations of medical necessity, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, where permitted by law and benefit plan sponsor, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. 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."

Ship to: ☐ Office ☐ Other _____ Date _____ Date Needed _____

**Dispense as Written**

Prescriber's Signature _____ Date _____

Electronic or digital signatures not accepted.

**Substitution permitted**

Prescriber's 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.