

IVIG (Immunoglobulin) ORDER FORM

REFERRAL TYPE				
<input type="checkbox"/> New Referral	<input type="checkbox"/> Order Renewal	<input type="checkbox"/> Restart	<input type="checkbox"/> Frequency Change	<input type="checkbox"/> Dosage Change
PREFERRED LOCATION				
<input type="checkbox"/> 2730 University Blvd. West Suite 714 Wheaton, MD 20902	<input type="checkbox"/> 14995 Shady Grove Road Suite 250 Rockville, MD 20850	<input type="checkbox"/> 5454 Wisconsin Avenue Suite 600 Chevy Chase, MD 20815		
<input type="checkbox"/> 18111 Prince Philip Drive Suite 323 Olney, MD 20832	<input type="checkbox"/> 161 Thomas Johnson Drive Suite 250 Frederick, MD 21702	<input type="checkbox"/> 2021 K Street, NW Suite 300 Washington, DC 20006		
		<input type="checkbox"/> 8270 Willow Oaks Corporate Drive Suite 150 Fairfax, VA 22031		
PATIENT INFORMATION				
Name:		DOB:	Email:	
Address:		Weight:	KG	LBS
				Phone:
REFERRING PHYSICIAN INFORMATION				
Name:			NPI:	
Office Contact Name:		Phone:	Fax:	
Address:				
IVIG ORDER				
<i>OFF-LABEL diagnosis, dose and frequency are subject to medical review and approval.</i>				
Dose/Frequency:				
Diagnosis:				
<input type="checkbox"/> D69.3—Immune thrombocytopenic purpura <input type="checkbox"/> D80.1—Nonfamilial hypogammaglobulinemia <input type="checkbox"/> D83.0—Common variable immunodeficiency with predominant abnormalities of B-cell numbers and function <input type="checkbox"/> G61.0—Guillain-Barre syndrome <input type="checkbox"/> G61.81—Chronic inflammatory demyelinating polyneuritis <input type="checkbox"/> G61.89—Other inflammatory polyneuropathies <input type="checkbox"/> G70.00—Myasthenia gravis w/o (acute) exacerbation <input type="checkbox"/> G73.7—Myopathy in diseases classified elsewhere <input type="checkbox"/> M33.12—Other dermatomyositis with myopathy <input type="checkbox"/> M33.19—Other dermatomyositis with other organ involvement <input type="checkbox"/> M33.22—Polymyositis with myopathy <input type="checkbox"/> Other Diagnosis: _____ ICD-10 Code (Required): _____				
Special Instructions:				
Physicians Signature:			Date: _____ <i>(Order is Valid for One Year)</i>	
REQUIRED DOCUMENTATION				
Please fax the following documents and records:				
<ul style="list-style-type: none"> ● Patient Demographics ● Two most recent office notes (Supporting the DX and treatment ordered) ● Most recent labs that include values for: <ul style="list-style-type: none"> ● CMP ● IgA, IgG, IgM 		<ul style="list-style-type: none"> ● Copy of the patient's insurance card(s) – front and back ● Medication History ● For continuation of treatment, include the last infusion note 		
<i>We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.</i>				