45 Earhart Drive, Suite 110, Amherst, NY 14221

IMMUNE GLOBULIN (IVIG) AUTHORIZATION AND RE-AUTHORIZATION

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Last Name	First Name	Today's Date	Date Needed
Parent/Guardian		Prescriber	Hospital/Clinic
Home Phone Number ( )	Work Phone Number ( )	Phone Number ( )	Fax Number ( )
Home Address	City State Zip	Address	City State Zip
Ship To: ☐ Prescriber ☐ Patient's Home		Office Contact	Prescriber Speciality
Language Preference ☐ English ☐ Spanish ☐ Other			
Known Allergies:		Contact Preference ☐ Phone ☐ Fax ☐ Email: ____	
Weight _______ Lbs. Height ____ Ft _____ In	Date of Birth ____ / ___ / ____ Sex ☐ M ☐ F	Special Instructions	

INSURANCE INFORMATION

Fill out entirely or fax a copy of patient's insurance card (both sides):

Primary Insurance: ____________________

Name of Insured: ____________________

Policy #: ____________________

Group #: ____________________

Phone #: ____________________

Rx Drug Card #: ____________________

Secondary Insurance: ____________________

Name of Insured: ____________________

Policy #: ____________________

Group #: ____________________

Phone #: ____________________

Rx Drug Card #: ____________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: ____________________

ICD9 Code: ____________________

Secondary Diagnosis: ____________________

ICD9 Code: ____________________

☐Use of previous IVIGproduct: ____________________

IgALevel and Date: ____________________

IgGLevel and Date: ____________________

Hct and Date: ____________________

Platelets Count and Date: ____________________

Additional History: ____________________

____

____

☐New Authorization ☐Reauthorization*

Drug Name: ____________________

Dose: ____________________

Frequency: ____________________

Expected duration of therapy: ____________________

*For reauthorization, please submit documentation:

1. IgG response
2. Platelet count response
3. Number of infection episodes or symptoms
4. Number of adverse side effects
5. Compliance with therapy

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