



Vivaglobin (SCIG) Enrollment Form

216 S. Polk, Amarillo, TX 79101

Patient Referral/Medication Request Form

Phone: 1-866-629-6779 • Toll Free Fax: 1-866-217-8034

Patient Name _____ Date of Birth: _____ Sex: Male Female
 Home Address _____ City: _____ State: _____ ZIP: _____
 Shipping Address: Home Physician Other _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 SSN: _____ Allergies: NKA _____
 Emergency Contact Name: _____ Phone: _____

Insurance Information (Fill out completely OR fax a copy of patient's insurance card – both sides)

Primary Insurance: _____ Phone: _____ Name of Insured: _____
 Policy #: _____ Group #: _____ Rx Drug Card #: _____
 Secondary Insurance: _____ Phone: _____ Name of Insured: _____
 Policy #: _____ Group #: _____ Rx Drug Card #: _____

Medical Necessity Assessment:

Primary Diagnosis: _____
 ICD-9 Code: _____
 Secondary Diagnosis: _____
 Use of previous SQIG product _____
 IgA Level & Date: _____ IgG Level & Date: _____
 Hct & Date: _____ Platelets Count & Date: _____
 Additional History: _____

Treatment Settings & Patient Training

Step 1 Initial Treatment Setting: Physician Office Outpatient Clinic Inpatient Home
1A Product will be supplied by: Physician Access Specialty Pharmacy Other _____
Step 2 Patient Training: Do you want the Specialty Pharmacy to train the patient? Yes No
Step 3 Final Treatment Setting: Physician Office Outpatient Clinic Inpatient Home
3A Product will be supplied by: Physician Access Specialty Pharmacy Other _____

Initial dose 100mg – 200mg/kg SC once weekly.

IVIG Conversion:

Weekly SCIG dose = IVIG dose x 1.37 ÷ IVIG weekly interval originally given.
 Total monthly grams of Vivaglobin® _____ ÷ 0.160 grams per ml. = _____ mL per month
 Divide mL per month into appropriate weekly dose and round to appropriate vial size(s).

Vivaglobin® (160 mg per mL)
Available in 3 ml (0.48 g), 10 mL (1.6g),
or 20 mL (3.2g) single-use vials

TAPE PRESCRIPTION HERE PRIOR TO FAXING REFERRAL OR COMPLETE THE FOLLOWING:

RX: Total weekly dose _____ grams (_____ Total mL) **Vivaglobin® (160mg per mL)** to be infused simultaneously into 1-2-3- 4 _____ subcutaneous sites using a pump over _____ hours. (Max rate 20ml/hr). Infusion frequency 1-2-3 _____ times per week.
Rotate sites to maintain skin health. Dispense 4-week supply = _____ mL with _____ refills. *Dispense in combination of single-use vial sizes to equal total mL prescribed for each dose.*

Prescription Type: New Continuing Therapy Restart Drug Allergies _____ NKA
 Anticipated Start Date: _____ Today's Date: _____

Physician's Signature: _____ M.D.
 Dispense as written Generic Substitution Permitted

Physician's Name: _____ Office Contact: _____
 Address: _____ Phone: _____
 City/State/ZIP: _____ Fax: _____
 NPI #: _____ DEA # _____ License #: _____