



Intravenous or Subcutaneous Immunoglobulin Request Form

Please complete all the questions fully. Failure to do so may result in delay or possible denial of claims.

See Medical Policy RX504.003, Immunoglobulin (Ig) Therapy (Including Intravenous [IVIg] and Subcutaneous Ig)

Name of office or facility _____ FAX # _____

Contact Person _____ Phone # _____
(please print)

Group # _____ Patient Name _____

Subscriber # _____ Subscriber Name _____

Referral # _____ Address _____
(if applicable) (City) (State) (Zip)
(Street)

Primary Diagnosis _____ Date _____

Secondary Diagnoses _____ Date _____
_____ Date _____
_____ Date _____

Date of initiation of IVIG administration (for renewal or continuation) _____

| Part A | | | | | |
|---|-----------------------------------|------|---------------|------------------|------|
| Have serum immunoglobulins assays been done? Yes _____ No _____ If so, report results below. For IVIG continuation, please include levels that were done prior to initiation IVIG therapy, and the date. | | | | | |
| Test | Level Prior to Initiation of IVIG | Date | Current Level | Lab Normal Range | Date |
| Total IgG | | | | | |
| G-Subclass 1 | | | | | |
| G-Subclass 2 | | | | | |
| G-Subclass 3 | | | | | |
| G-Subclass 4 | | | | | |
| Have any Immune Challenge Tests been done? Yes _____ No _____ If so, report type of test and response. | | | | | |
| Test | Response | | | Date | |
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Part B

Indicate criteria or positive tests used to establish diagnosis.

| Criteria or Test | Date |
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Part C

| Proposed treatment program | IVIG Dose | Frequency |
|----------------------------|-----------|-----------|
| | | |
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| | | |

Proposed date of Retesting or Reassessment: _____

Please list any complications, additional symptoms, or other pertinent information _____

For off-label use, please give rationale, including alternative interventions that have failed or are contraindicated _____

Practitioner Name Printed Date

Practitioner Signature NPI Number Date