



IVIG Patient Demographics Form

816 N. 6th Ave.
Phoenix, AZ 85003
Phone: (844) 482-2005
Fax: (833) 437-2301

PATIENT INFORMATION		PRESCRIBER INFORMATION	
Patient Name: _____	Prescriber Name: _____	State License: _____ NPI #: _____	
Address: _____	DEA: _____		
City, State, Zip: _____	Phone: _____ Fax: _____		
Phone: _____ Alt. Phone: _____	Address: _____		
DOB: _____ Last 4 SSN: _____	City, State, Zip: _____		
Gender: M F Height: _____ Weight: _____	Office Contact: _____		
Allergies: _____			
INSURANCE INFORMATION - May also scan front and back of insurance card and attach to form			
Primary Insurance: _____	Rx Card (PBM): _____	BIN: _____ PCN: _____	
Member ID #: _____	Group #: _____		
Plan # _____	Phone: _____		
Group #: _____	Subscriber Name/DOB: _____		
Phone: _____			
DIAGNOSIS / CLINICAL INFORMATION - Please attach recent clinical notes and labs with this form			
<input type="checkbox"/> G61.81 CIDP	<input type="checkbox"/> M33.90 Dermatomyositis	<input type="checkbox"/> Other Code: _____	
<input type="checkbox"/> G61.89 MMN	<input type="checkbox"/> D80.0 Congenital hypogammaglobulinemia		
<input type="checkbox"/> G35 MS (Relapsing Remitting)	<input type="checkbox"/> M33.20 Polymyositis		
<input type="checkbox"/> G61.0 GBS	<input type="checkbox"/> D83.9 CVID		
<input type="checkbox"/> G70.01 MG with acute exacerbation	<input type="checkbox"/> D81.9 SCID (unspecified)		
PRESCRIPTION - Please attached copy of SIGNED PRESCRIPTION with this form			
Please include the following information on prescription:			
<ul style="list-style-type: none"> IVIG weight-based dose Directions for administration and refills (if applicable) Pre-medication/s and/or anaphylaxis requirements Patient's flush requirements 			
ADMINISTRATION			
Route	Delivery		
<input type="checkbox"/> Peripheral <input type="checkbox"/> Port <input type="checkbox"/> SubQ	Patient Needs Dose by:	Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Office <input type="checkbox"/> Other:	

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.

Fax completed form and copy of prescription to: (833) 437-2301

Thank you for choosing AvasaRX