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: _____
Address: _____	State License: _____ NPI #: _____
City, State, Zip: _____	DEA: _____
Phone: _____ Alt. Phone: _____	Phone: _____ Fax: _____
DOB: _____ Last 4 SSN: _____	Address: _____
Gender: M F Height: _____ Weight: _____	City, State, Zip: _____
Allergies:	Office Contact: _____

INSURANCE INFORMATION - May also scan front and back of insurance card and attach to form

Primary Insurance: _____	Rx Card (PBM): _____
Member ID #: _____	BIN: _____ PCN: _____
Plan # _____	Group #: _____
Group #: _____	Phone: _____
Phone: _____	Subscriber Name/DOB: _____

DIAGNOSIS / CLINICAL INFORMATION - Please attach recent clinical notes and labs with this form

☐ G61.81 CIDP	☐ M33.90 Dermatomyositis	☐ Other Code:
☐ G61.89 MMN	☐ D80.0 Congenital hypogammaglobulinemia	
☐ G35 MS (Relapsing Remitting)	☐ M33.20 Polymyositis	
☐ G61.0 GBS	☐ D83.9 CVID	
☐ G70.01 MG with acute exacerbation	☐ D81.9 SCID (unspecified)	

PRESCRIPTION - Please attached copy of SIGNED PRESCRIPTION with this form

Please include the following information on prescription:

- 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	
☐ Peripheral ☐ Port ☐ SubQ	Patient Needs Dose by:	Ship to: ☐ Patient ☐ Office ☐ Other:

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

Thank you for choosing AvasaRX