Phone: 713-360-2100 or 1-855-497-7956
Fax: 713-244-5120 or 1-844-486-2186

Date: ________________

Enrollment Form
Statement of Medical Necessity
Immune Globulin
Auto Immune Disorder

Patient Information

Patient Name: ____________________
Address: ____________________
City: ____________ State: ________ Zip: ________
DOB: ____________ Gender: Male Female
Height: ________ Weight: ________ Weight Date: ________
Phone: ____________ Cell: ____________

Patient Records (Please Attach and Fax):
1. Insurance Card(s) and Demographic Information
2. Recent Clinical Assessment Note or H&P
3. Current Medication List
4. Diagnostics Tests

Allergies: ____________________

NKDA **Initiate Appeal Reason:** ____________________

Statement of Medical Necessity - Primary Diagnosis

ICD-10 Description	Code	ICD-10 Description	Code
Guillain-Barre Syndrome	G61.0	Myasthenia Gravis with Acute Exacerbation	G70.01
Chronic Inflammatory Demyelinating Polyneuritis	G61.81	Myasthenia Gravis without Acute Exacerbation	G70.00
Multifocal Motor Neuropathy	G61.82	Pemphigus, Unspecified	L10.9
Critical Illness Polyneuropathy	G62.81	Pemphigus Foliaceus	L10.2
Dermatopolymyositis, Unspecified, Organ Involvement, Unspecified	M33.90	Pemphigus Vulgaris	L10.0
Myasthenic Syndromes in other Diseases Classified Elsewhere	G73.3	Hereditary and Idiopathic Neuropathy, Unspecified	G60.9
Inflammatory Polyneuropathy, Unspecified	G61.9	Polymyositis, Organ Involvement Unspecified	M33.20
Multiple Sclerosis	G35	Stiff-Man Syndrome	G25.82
		Other: ____________	________

Prescription and Orders

Is this the first dose? Yes No If No, date first dose given: ________ Target Start Date: ________ Next MD Appointment: ________

Administer IVIg Product: Pharmacist to determine (or) Brand: ________________

Dose: (please select one and provide complete information)

Loading: 2g/kg IV via gravity/pump over ______ days.

Maintenance: _____ g/kg via gravity/pump Over _____ day(s) Every _____ weeks for _____ cycle(s)

Other Regimen: ____________________ **Refills:** ______

Dispense: 4 week supply

(Doses will be rounded to the nearest 5gm vial)

Access: Peripheral PICC Port Other: ________________

Biocure Flushing Protocol is the following:

NS Flushes (10mL) #QS:	Adult: Heparin 100 units/mL (5mL) #QS:	Pedi: Heparin 10 units/mL #QS:
PIV: 3mL to 5mL IV pre/post + prn.	PIV: 3mL IV post.	PIV: 3mL IV post (3mL)
PAC: 10mL IV pre/post + prn	PAC: 5mL IV Post	

Adverse/Anaphylactic Reactions: Anaphylaxis kit will be provided containing one of each of the following:

Diphenhydramine 25 mg capsules and 50 mg/mL 1mL, vial Epinephrine 1:1000 (1mg/mL) syringe, 0.9% NaCl 500 mL bag, SIG: U.D. prn anaphylaxis

Pre-Treatment Orders:

APAP _____ 500mg or _____ 325mg po 15-30 minutes before the infusion starts
Diphenhydramine 25mg po 15-30 minutes before the infusion starts
Other: ____________________
Aspirin 325mg po 15-30 minutes before the infusion starts
None

Labs:

Results will be faxed to physician's office. Labs will not be drawn on weekends or Holidays. Not approriate for STAT Labs.

MD Office to Manage Labs

Biocure Lab Protocol (For IV patients only) :
CBC, BUN, Creatinine at day 1 of first infusion and then every 3rd Cycle

Prescriber Information

Prescriber Name: ____________________
Address: ____________________
City: ____________ State: ________ Zip: ________
Phone: ____________ Fax: ____________

Office Contact (required): ____________________
License: ____________________
DEA: ____________________
NPI: ____________________

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. By signing this form and utilizing our services, you are authorizing BioCure LLC and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and Co-pay Assistance Foundations

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Prescriber Signature: ____________________ Date: ____________

Form Revision Date: February 14th, 2017