BIOCURE

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
Primary Immune Deficiency

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
Common Variable Immunodeficiency (CVID)	
☐ with Predominant Abnormalities of B- Cell numbers and function	D83.0
☐ with Predominant Immunoregulatory T-Cell Disorders	D83.1
☐ with Autoantibodies to B or T Cells	D83.2
☐ Other Common Variable Immunodeficiency (CVID)	D83.8
☐ Common Variable Immunodeficiency (CVID), unspecified	D83.9
Severe Combined Immunodeficiency [SCID]	
☐ with Reticular Dysgenesis	D81.0
☐ with low T and B-cell numbers	D81.1
☐ with low or normal B-cell numbers	D81.2
☐ **Major Histocompatibility Complex Class I Deficiency**	D81.6
☐ **Major Histocompatibility Complex Class II Deficiency**	D81.7

ICD-10 Description	Code
☐ Other Combined Immunodeficiency	D81.89
☐ Combined Immunodeficiency, Unspecified	D81.9
☐ Hereditary Hypogammaglobulinemia	D80.0
☐ Nonfamilial Hypogammaglobulinemia	D80.1
☐ Immunodeficiency with Increased Immunoglobulin M [IgM]	D80.5
☐ Selective Deficiency of A (IgA)	D80.2
☐ Selective Deficiency of M (IgM)	D80.4
☐ Wiskott-Aldrich Syndrome	D82.0
☐ Selective Deficiency of G (IgG) subclasses	D80.3
☐ Other: _____	_____

Prescriptions and Orders

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

Product: ☐ Pharmacist to determine (or) ☐ Brand: _____

Dose: (please select one and provide complete information)
☐ **Intravenous:** _____ mg/kg IVIG via pump or gravity every _____ weeks for _____ cycles (Round to the nearest 5gm)
☐ **Subcutaneous:** _____ mg/kg SCIG via Freedom 60 pump divided into weekly doses for _____ cycles. (Round to the nearest gm)
☐ **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:
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
EpiPen® 0.3mg 2 -pk, dispense #1: 0.3 mg IM prn severe anaphylactic reaction times one dose; may repeat one time for patients weighing greater than or/equal to 30kg

Pre-Treatment:
☐ 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, IgG*, and Creatinine at day 1 of first infusion and then every 3rd Cycle
*IgG levels drawn at 3rd cycle only

Prescriber Information

Prescriber Name: _____ Office Contact (required): _____
Address: _____ License: _____
City: _____ State: _____ Zip: _____ DEA: _____
Phone: _____ Fax: _____ 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

Prescriber Signature: _____ **Date:** _____