



BIOFUSION

Immunoglobulin – Auto Immune Disorder Enrollment Form – Statement of Medical Necessity

Patient Information

Patient Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 DOB: _____ Gender: Male Female
 Height: _____ Weight: _____
 Phone (Home): _____ (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

Allergies _____
 NKDA

Statement of Medical Necessity—Primary Diagnosis

- | | |
|--|--|
| <input type="checkbox"/> Acute Infective Polyneuritis (Guillain-Barre Syndrome) 357.0 | <input type="checkbox"/> Myasthenia Gravis with (Acute) Exacerbation 358.01 |
| <input type="checkbox"/> Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) 357.81 | <input type="checkbox"/> Myasthenia Gravis without (Acute) Exacerbation 358.0 |
| <input type="checkbox"/> Critical Illness Polyneuropathy (Acute Motor Neuropathy) 357.82 | <input type="checkbox"/> Pemphigus (Pemphigus Foliaceus, Pemphigus Vulgaris) 694.4 |
| <input type="checkbox"/> Dermatomyositis 710.3 | <input type="checkbox"/> Peripheral Neuropathy (Unspecified) 356.9 |
| <input type="checkbox"/> Lambert-Eaton Myasthenic Syndrome 358.1 | <input type="checkbox"/> Polymyositis 710.4 |
| <input type="checkbox"/> Multifocal Motor Neuropathy (MMN) 357.9 | <input type="checkbox"/> Stiff-Person Syndrome 333.9 |
| <input type="checkbox"/> Multiple Sclerosis (MS) 340.0 | <input type="checkbox"/> Other: _____ |

Prescription and Orders

Is this the first dose? Yes No If No, date first dose given: _____ Next dose due: _____

Administer IVIG Product: Pharmacist to determine (or) Formulation _____

Dose: (please select one and provide complete information)

- 2 g/kg over _____ days, repeat course every _____ week(s) for _____ cycle(s)
 _____ mg/kg or _____ g every _____ week(s) for _____ cycle(s)
 Other Regimen: _____

Infusion Rate: (please select one and provide complete information)

- _____ cc/hr for the first hr _____ cc/hr for the second hr _____ cc/hr thereafter
 Start at _____ cc/hr, then increase by _____ cc/hr every _____ minutes to maximum rate _____ cc/hr
 Pharmacist to determine

Access: Peripheral PICC Port Other: _____

Flushing: Biofusion Protocol (heparin 100 unit/mL, 0.9% NaCl, D5W)

Adverse/Anaphylactic Reactions: Anaphylaxis kit will be provided containing:

diphenhydramine 25 mg capsules and 50 mg/mL 1 mL vial
 Epinephrine 1:1000 (1mg/mL) syringe, 0.9% NaCl 500 mL bag

Pre-Treatment:

- Tylenol _____ 500 mg or _____ 325 mg po 15-30 minutes before the infusion starts
 Benadryl 25 mg po 15-30 minutes before the infusion starts
 Aspirin 325 mg po 15-30 minutes before the infusion starts
 None
 Other: _____

MONITOR

Observe: Vital signs prior to infusion. Blood pressure and pulse every 30 minutes until stable infusion rate, then every hour.

Watch for: Signs of fluid overload, cardiovascular symptoms, allergic reactions, skin rash, fever, and moderate to severe headache.

Call/Page MD: For adverse events, stop the infusion. Can restart the infusion at the same or lower rate pending physician's approval or if symptoms subside.

Labs:

- BUN and Serum Creatinine; Fax results Prior to first infusion After _____ infusion
 Other: _____ Fax results Prior to first infusion After _____ infusion

Physician Information

Physician 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.

Physician Signature: _____ Date: _____