

IMMUNE DISORDERS (GENERAL)
TELEPHONE 1-866-792-2731 FAX 1-866-811-7450

1. PATIENT INFORMATION *To be completed by the patient*

Last Name		First Name		M.I.
Street Address				
City		State	ZIP	
Day Telephone # (+Area Code)		Night Telephone # (+Area Code)	Mobile Telephone # (+Area Code)	
Date of Birth (MM/DD/YYYY)		Social Security #	Sex (Check One) <input type="checkbox"/> M <input type="checkbox"/> F	
Parent/Guardian Name				

INSURANCE INFORMATION

Primary/Medical Insurance		Secondary/Pharmacy Insurance	
Cardholder Name & ID # (If Not Patient)		Cardholder Name & ID # (If Not Patient)	
Group/Policy #		Group/Policy #	
Insurance Telephone # (+Area Code)		Insurance Telephone # (+Area Code)	
Employer		Medicaid #	

ALTERNATE SHIPPING ADDRESS

Last Name		First Name		M.I.
Street Address				
City		State	ZIP	

Caremark is committed to protecting the privacy of your health information. We will hold your health information in confidence and will only use and disclose it in accordance with applicable law.

2. PHYSICIAN INFORMATION *To be completed by the physician and staff*

Prescriber's Last Name		Prescriber's First Name	
Hospital/Clinic		Office Contact	
Street Address			
City		State	ZIP
Telephone # (+Area Code)		Fax # (+Area Code)	E-Mail Address
Prescriber's License #		DEA #	NPI #
UPIN#		Medicaid License #	

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS:

279 Immune Mechanism Disorder 279.0 Deficiency of Humoral Immunity
 279.00 Hypogammaglobulinemia NOS 279.06 Common Variable Immunodeficiency
 279.3 Immunity Deficiency NOS
 Other _____

(Please Indicate ICD-9 CM Code & Description)

SECONDARY DIAGNOSIS:
(You Must Complete the Clinical History and Assessment Related to IGIV Therapy Section Below.)

PERTINENT MEDICAL HISTORY:

Height ____ Weight ____ As of Date ____ / ____ / ____
 Allergies _____
 Therapy Start Date ____ / ____ / ____ Length of Therapy ____
 Date of Last Infusion ____ / ____ / ____
 Deliver Product to Physician's Office Patient's Home Other _____
 If Administered in Home, Should Caremark Refer/Coordinate Nursing for Administration? Yes No
 Recommended Agency? _____

CLINICAL HISTORY AND ASSESSMENT RELATED TO IGIV THERAPY:

PERTINENT TEST RESULTS:

PROPOSED TREATMENT:

Rx

IGIV Product (Rph to Verify) _____ **Date** ____ / ____ / ____

Carimune® NF Dosage _____
 Gammagard® Liquid Directions _____
 GammaSTAN™ I.V. Access _____
 Gamunex® Flushing Protocol _____
 Octagam®

Ancillary Supplies and Kits Provided as Needed for Administration.

Sig	Quantity

Refill ____ Times Substitution Allowed
 Dispense As Written

Prescriber's Signature _____ **Date** _____

3. FAX COMPLETED FORM TOLL-FREE TO CAREMARK® @ 1-866-811-7450

Please include copies of the patient's insurance cards (front & back) when faxing the referral to expedite benefit clearance.
Thank you for choosing Caremark!