

INTRAVENOUS IMMUNE GLOBULIN (IVIG)

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:

ICD-9 CM:
 340 Multiple Sclerosis

Other

Date of Diagnosis / /

Rx

Date / /
 Gammagard® S/D Dosage ____
 Gamimune® N Directions ____
 Gammar®-P.I.V. I.V. Access ____
 Panglobulin® Flushing Protocol ____
 Other ____

Ancillary Supplies and Kits Provided as Needed for Administration.

Sig	Quantity

Refill ____ Months
 Dispense As Written Substitution Allowed

Prescriber's Signature	Date
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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!