

Immunoglobulins (Ig) Enrollment Form



Fax Referral To: 1-877-232-5455

Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813

Phone: 1-800-896-1464

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____

Address: _____ City, State, ZIP Code: _____

Gender: Male Female

Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Alternate Phone: _____

If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____

Relationship to minor: _____

Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____

NPI #: _____ DEA #: _____ Group or Hospital: _____

Address: _____ City, State, ZIP Code: _____

Phone: _____ Fax: _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

Insurance Company: _____ ID#: _____

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: Patient Office Other: _____

Service Location:

Home or Coram AIC Diluents, Flushes, Supplies, Nursing Services for drug administration/therapy teach train

MD Office/Other Drug Only for facility administration

Diagnosis (ICD-10):

C91.10 Chronic lymphocytic leukemia of B-cell type not having achieved remission

D69.3 Immune thrombocytopenic purpura

D80.2 Selective deficiency of IgA

D80.4 Selective deficiency of IgM

D80.6 Antibody deficiency with near-normal Immunoglobulins or with hyperimmunoglobulinemia

D80.7 Transient hypogammaglobulinemia

D81.2 SCID with low or normal B cell numbers

D81.6 Major histocompatibility complex class I

D81.89 Other combined immunodeficiencies

D82.0 Wiskott-Aldrich syndrome

D82.4 Hyperimmunoglobulin E syndrome

D83.0 Common Variable Immunodeficiency with Predominant abnormalities of B cell numbers and function

D83.1 Common Variable Immunodeficiency with predominant Immunoregulatory T cell disorders

D83.2 Common Variable Immunodeficiency with autoantibodies to B or T cells

D83.9 Common Variable Immunodeficiency, unspecified

G11.3 Cerebellar ataxia with defective DNA

G61.0 GBS

G61.82 MMN

G70.01 MG with acute exacerbation

M33.90 Dermatomyositis

D80.0 Congenital Hypogammaglobulinemia

D80.3 Selective deficiency of IgG subclasses

D80.5 Immunodeficiency with increased IgM

D81.0 SCID with reticular dysgenesis

D81.5 Purine nucleoside phosphorylase deficiency

D81.7 Major histocompatibility complex class II

D81.9 SCID (Unspecified)

D82.1 De George's syndrome

G35 MS (Relapsing Remitting)

G61.81 CIDP

G70.00 MG without acute exacerbation

M33.20 Polymyositis

Other Code: _____ Description: _____

Patient Clinical Information:

Allergies/rxn: _____

History of: Headache Diabetes CHF Renal issues

First time receiving Immunoglobulin? Yes No

If No, previous product used: _____

Height: _____ in/cm

Weight: _____ lb/kg

If first dose, please provide IgA level: _____

Last dose given: _____ Next dose due: _____

Immunoglobulins (Ig) Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____
 Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION **Select One Immunoglobulin Product:**

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Asceniv 10% | <input type="checkbox"/> Gammagard Liq 10% | <input type="checkbox"/> Gamunex-C 10% | <input type="checkbox"/> Octagam <input type="checkbox"/> 5% <input type="checkbox"/> 10% |
| <input type="checkbox"/> Bivigam 10% | <input type="checkbox"/> Gammagard S/D <input type="checkbox"/> 5% <input type="checkbox"/> 10% | <input type="checkbox"/> Hizentra 20% PFS (SC route) | <input type="checkbox"/> Panzyga 10% |
| <input type="checkbox"/> Cutaquig 16.5% (SC route) | <input type="checkbox"/> Gammaked 10% | <input type="checkbox"/> Hizentra 20% vials (SC route) | <input type="checkbox"/> Privigen 10% |
| <input type="checkbox"/> Cuvitru 20% (SC route) | <input type="checkbox"/> Gammplex <input type="checkbox"/> 5% <input type="checkbox"/> 10% | <input type="checkbox"/> HyQvia 10% (SC route) | <input type="checkbox"/> Xembify 20% (SC route) |
| <input type="checkbox"/> Gamastan (IM route) | <input type="checkbox"/> Other: _____ | | |

Route: SC IV **Dose:** _____ grams _____ mg/kg (dose will be rounded to the nearest vial size)

Directions: Daily x _____ Day (s), every _____ Week Infuse at _____ mL/hr or infuse over _____ hours

Follow FDA package insert infusion rate directions Other: _____

Nursing: Please arrange nursing for administration Patient may be taught to self-infuse

OK to administer first dose in the home if pharmacy deems appropriate

Lab Orders: _____

ITEMS BELOW THIS LINE WILL ONLY BE SENT FOR INFUSIONS DONE AT HOME/CORAM AIS

MEDICATION	ROUTE	DOSE /STRENGTH	DIRECTIONS
Catheter: <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> PICC	IV	NA	Catheter Care/Flush – Only on IG drug admin days – SASH or PRN to maintain IV access and patency <ul style="list-style-type: none"> PIV – NS 5 mL (Heparin 10 units/ mL 3-5 mL if multiple days) PORT/PICC – NS 10 mL & Heparin 100 units/mL 3-5 mL, and/or 10 mL sterile saline to access port a cath
Hydration: <input type="checkbox"/> NS <input type="checkbox"/> D5W	IV	Pre: <input type="checkbox"/> 500 mL <input type="checkbox"/> 1000 mL <input type="checkbox"/> Other: _____ Concurrent: <input type="checkbox"/> 500 mL <input type="checkbox"/> 1000 mL <input type="checkbox"/> Other: _____ (Not to be infused using the same access as Ig) Post: <input type="checkbox"/> 500 mL <input type="checkbox"/> 1000 mL <input type="checkbox"/> Other: _____	Hydration max infusion rate _____ mL/hr (Adult max rate 250 mL/hr unless otherwise indicated)
<input type="checkbox"/> Diphenhydramine ** For rash or hives (If oral, patient may be instructed to purchase from retail)	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	<input type="checkbox"/> 25 mg-50 mg <input type="checkbox"/> Peds: 1 mg/kg <input type="checkbox"/> Other: _____	<input type="checkbox"/> PRN mild/moderate allergic reaction <input type="checkbox"/> Premed 30 minutes prior to infusion <input type="checkbox"/> Initial dose (IV only): Administer 25 mg x 1 dose; may repeat in 3-5 minutes if needed <input type="checkbox"/> Subsequent doses: may repeat every 4-6 hours as needed (Adult max 100 mg/day) <input type="checkbox"/> Other: _____
<input type="checkbox"/> Acetaminophen ** For aches, pain or fever (patient may purchase from retail)	PO	<input type="checkbox"/> 325 mg-650 mg <input type="checkbox"/> Other: _____	<input type="checkbox"/> Premed 30 minutes prior to infusion <input type="checkbox"/> May repeat every 4-6 hours as needed (Adult max 2000 mg/day) <input type="checkbox"/> Other: _____
<input type="checkbox"/> Lido/Prilocaine 2.5%/2.5% <input type="checkbox"/> Lidocaine 4%	TOP	30-60 grams	Apply to injection sites at least 1 hour before access Cover with occlusive dressing
Epinephrine **home nursing requirement**	IM	<input type="checkbox"/> Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) <input type="checkbox"/> Peds 1:2000, 0.3 mL (15-30 kg/33-66 lbs) <input type="checkbox"/> Infant 0.1 mL/0.1 mL, 0.1mL (7.5-15 kg/16.5-33lbs)	PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed
<input type="checkbox"/> Additional Medication: _____	Other:	Other: _____	Other: _____

Quantity: 1 cycle 1 month 3 months Other: _____ Refills: 1 year Other: _____

RX includes related diluents, pumps, DME, ancillary supplies as necessary for drug administration/catheter maintenance.

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute Prescriber's Signature: _____ Date: _____	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature: _____ Date: _____
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _____ ATTN: New York and Iowa providers, please submit electronic prescription	

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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