CarePartners Specialty Infusion

Immune Globulin Immunology Enrollment Form

Fax Referral To: 866-832-7180
Phone: 866-852-0202

To better serve your patient and facilitate insurance authorization, please attach the following:

- **Patient demographics, H&P, and labs**
- **The front and back of insurance & prescription drug card**
- **Labs – Antibody testing, BUN/SCr, IgA, IgG (including subclasses) levels**

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Cell Phone: _____
Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
DEA #: _____ NPI #: _____
Contact Person: _____

CLINICAL INFORMATION

DIAGNOSIS:

- ☐ D81.9 Combined Immunodeficiency, Unspecified
- ☐ D83.9 Common Variable Immunodeficiency (CVID)
- ☐ D80.0 Hereditary Hypogammaglobulinemia
- ☐ D84.9 Immunodeficiency, Unspecified
- ☐ D80.5 Immunodeficiency with Hyper IgM
- ☐ D80.1 Nonfamilial Hypogammaglobulinemia
- ☐ D80.2 Selective IgA Immunodeficiency
- ☐ D80.3 Selective IgG Immunodeficiency
- ☐ D80.4 Selective IgM Immunodeficiency
- ☐ D81.0 Severe Combined Immunodeficiency (SCID)
- ☐ D82.0 Wiskott-Aldrich Syndrome
- ☐ Other: _____

PATIENT EVALUATION:

Has patient previously received IVIG? ☐ Yes ☐ No
Patient Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in
Allergies: _____
Requested Therapy Start Date: _____

Pharmacy to coordinate home health nursing visit and/or nurse training:
☐ Yes ☐ No

If home health nursing coordination not necessary, please indicate reason:
- ☐ MD office or infusion center to administer to patient
- ☐ Home health nursing already coordinated
- ☐ Patient already trained on subcutaneous infusion

PRESCRIPTION INFORMATION

MEDICATION

- ☐ Gammagard Liq 10%
- ☐ Gammagard SD 5%
- ☐ Gammagard SD 10%
- ☐ Gammaked 10%
- ☐ Gammaplex 5%
- ☐ Gammaplex 10%
- ☐ Gamunex-C 10%
- ☐ Hizentra 20% Vials/PFS
- ☐ Panzyga 10%
- ☐ Octagam 5%
- ☐ Octagam 10%
- ☐ Privigen 10%
- ☐ Xembify 20%
- ☐ Other: _____
- ☐ **Pharmacy to select IG**

Infusion Route: ☐ **Intravenous infusion** ☐ **Subcutaneous infusion**

DOSE AND DIRECTIONS:

☐ Infuse _____ GRAMS daily for _____ day(s), every _____ week(s).
-OR-
☐ Pharmacy to calculate based on the following weight: _____ ☐kg ☐lbs
_____ GRAMS/KG divided over _____ day(s), every _____ week(s).
-OR-
☐ OTHER: _____

☐ OK to round to the nearest vial size
☐ +/- 4 days to allow scheduling flexibility
Multiple doses will be administered on consecutive days unless ordered otherwise.
☐ Non-consecutive days only

Rate protocol: Titrate initial and maintenance infusions per manufacturer's product labeling.

QUANTITY DISPENSE AND REFILLS

Dispense 1 month supply with 1 year refill (unless otherwise indicated below)

☐ Dispense 3-month supply with 1 year refill ☐ Other: _____

REQUIRED for HOME INFUSION

To be infused peripherally, unless otherwise indicated. ☐ PORT ☐ PICC ***Flushes to be provided per CarePartners protocol on page 2*

DELIVERY METHOD:

To be infused via gravity infusion, unless otherwise indicated ☐ MD prefers Infusion Pump

HYDRATION: Please select only if needed
☐ 0.9% NaCl _____ ml infused over _____ minutes
☐ D5W _____ ml infused over _____ minutes

*To be infused pre-infusion, unless otherwise specified below.
☐ Post-Infusion
☐ Concurrently with infusion

☐ **MD agrees that the order is to be infused per CarePartners Infusion protocols on page 2.**
- OR -
☐ MD has made adjustments to CarePartners Infusion protocols on page 2, and agrees to the remaining unadjusted protocols.

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Signature: _____ **Date:** _____

☐ Dispense as Written
☐ Product Substitution Permitted

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CarePartners Specialty Infusion Protocols

FLUSH PROTOCOL: to be provided for IVIG drug administration days only.

- 0.9% NaCl: 1-5ml intravenous (peripheral line) or 10ml intravenous (central line) before/after infusion, or as needed for line patency/SASH.
- Heparin 10 units/ml: 5ml intravenous (peripheral line) as needed for final flush.
- Heparin 100 units/ml: 5ml intravenous (central line) as needed for final flush.

PREMEDICATIONS: to be given 30 minutes prior to infusion *(PLEASE STRIKE THROUGH IF NOT REQUIRED)*

Diphenhydramine 25mg-50mg by mouth
For pediatric diphenhydramine patients:

- <2 years old: 1mg/kg up to max 6.25mg po
- 2-5 years old: 6.25mg-12.5mg po
- 6-12 years old: 12.5mg-25mg po

Acetaminophen 325mg-650mg by mouth
For acetaminophen patient's weighing < 60kg:
10-15mg/kg po

MEDICATIONS to be used as needed/requested by patient/nurse *(PLEASE STRIKE THROUGH IF NOT REQUIRED)*

- Diphenhydramine: May repeat premedication dose every 4-6 hours as needed. Adult max: 100mg/day.
- Acetaminophen: May repeat premedication dose every 4-6 hours as needed. Adult max: 3000mg/day.
- Lidocaine 2.5%/Prilocaine 2.5% topical (may dispense Lidocaine 4%) to injection sites at least 1 hour prior to needle insertion.

ANAPHYLAXIS PROTOCOL:
Intravenous infused patients: Pharmacy to provide the following as needed for anaphylactic reaction:

- Diphenhydramine 25mg- 50mg PO as needed for mild-moderate reaction. qty: 2
- Diphenhydramine 25mg- 50mg via slow IV push as needed for moderate-severe reaction. qty: one 50mg/ml vial
- Sodium Chloride 0.9% 500ml bag IV PRN for anaphylactic reaction. qty: 500ml
- Epinephrine 0.3mg (patient's weighing ≥ 30kg/66lbs)
- Epinephrine 0.15mg (patient's weighing between 15-30kg/33-66lbs)

Administer intramuscularly PRN severe allergic reaction. Call 911. May repeat x 1.

Subcutaneous infused patients: Pharmacy to provide the following as needed for anaphylactic reaction:

- Epinephrine 0.3mg (patient's weighing ≥ 30kg/66lbs)
- Epinephrine 0.15mg (patient's weighing between 15-30kg/33-66lbs)

Administer intramuscularly PRN severe allergic reaction. Call 911. May repeat x 1.

RX to include diluents, needles, syringes, ancillary supplies, home medical equipment to administer infusion.

Rate protocol: Titrate initial and maintenance infusions per manufacturer's product labeling.

ADDITIONAL ORDERS: