

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
- Studies – Nerve conduction, EMG, CSF, biopsy results

**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:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) | <input type="checkbox"/> G70.80 Lambert-Eaton Syndrome                    | <input type="checkbox"/> G13.0 Paraneoplastic Syndrome |
| <input type="checkbox"/> M33.10 Dermatomyositis  | <input type="checkbox"/> G61.82 Multifocal Motor Neuropathy (MMN)         | <input type="checkbox"/> M33.22 Polymyositis           |
| <input type="checkbox"/> G61.0 Guillain-Barré Syndrome                                   | <input type="checkbox"/> G35 Multiple Sclerosis (Relapsing/Remitting)     | <input type="checkbox"/> G25.82 Stiff-Person Syndrome  |
| <input type="checkbox"/> G72.41 Inclusion Body Myositis                                  | <input type="checkbox"/> G70.01 Myasthenia Gravis with Acute Exacerbation | <input type="checkbox"/> 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**

- |  |  |   |                                       |   |
|--|--|---|---------------------------------------|---|
| <input type="checkbox"/> Gammagard Liq 10% | <input type="checkbox"/> Gammaked 10%  | <input type="checkbox"/> Gamunex-C 10%          | <input type="checkbox"/> Octagam 5%   | <input type="checkbox"/> Xembify 20%                  |
| <input type="checkbox"/> Gammagard SD 5%   | <input type="checkbox"/> Gammaplex 5%  | <input type="checkbox"/> Hizentra 20% Vials/PFS | <input type="checkbox"/> Octagam 10%  | <input type="checkbox"/> Other: _____                 |
| <input type="checkbox"/> Gammagard SD 10%  | <input type="checkbox"/> Gammaplex 10% | <input type="checkbox"/> Panzyga 10%            | <input type="checkbox"/> Privigen 10% | <input type="checkbox"/> <b>Pharmacy to select IG</b> |

**Infusion Route:**  Intravenous infusion  Subcutaneous infusion

**DOSE AND DIRECTIONS:**

Pharmacy to calculate based on the following weight: \_\_\_\_\_ kg  lbs   
 Loading Dose: Infuse \_\_\_\_\_ grams daily for \_\_\_\_\_ day(s)  
- OR - Infuse \_\_\_\_\_ gram per kg divided over \_\_\_\_\_ day(s)  
 Maintenance Dose: Infuse \_\_\_\_\_ grams daily for \_\_\_\_\_ days, every \_\_\_\_\_ weeks  
- OR - Infuse \_\_\_\_\_ gram per kg divided over \_\_\_\_\_ day(s), every \_\_\_\_\_ week(s)  
 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.  Dispense as Written  
 **Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  Product Substitution Permitted

**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  $\geq$  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  $\geq$  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 in fusion.*

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

**ADDITIONAL ORDERS:**