CarePartners Specialty Infusion

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

IMMUNOGLOBULIN (IG) AUTOIMMUNE RX ENROLLMENT FORM

PATIENT INFORMATION

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

CLINICAL INFORMATION

Patient Weight: _____ ☐ kg ☐ lbs

Patient Height: _____ ☐ cm ☐ in

Allergies: _____

Has patient previously received IG? ☐ Yes ☐ No

☐ Patient already trained on subcutaneous infusion

☐ Pharmacy to coordinate home health nursing visit and/or nursing training

PRESCRIBER INFORMATION

Prescriber Name: _____

DEA #: _____ NPI #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Contact Person: _____

PRESCRIPTION INFORMATION Pharmacy to select IG if medication left blank

MEDICATION ☐ **Pharmacy to select IG** ☐ Brand _____

Infusion Route ☐ Intravenous ☐ Subcutaneous

Dose and Directions

» Pharmacy to calculate based on the following weight: _____ ☐ kg ☐ lbs

☐ Loading Dose: Infuse _____ GRAMS daily for _____ day(s)

-OR- Infuse _____ GRAM/KG divided over _____ day(s)

☐ Maintenance Dose: Infuse _____ GRAMS daily for _____ days, every _____ week(s)

-OR- Infuse _____ GRAM/KG divided over _____ day(s), every _____ week(s)

☐ Other _____

☐ +/- 4 days to allow scheduling flexibility ☐ OK to round to the nearest vial size

Multiple doses will be administered on consecutive days unless ordered otherwise.

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

DIAGNOSIS

☐ G04.81 Other Encephalitis and Encephalomyelitis

☐ M33.9 Dermatopolymyositis

☐ D69.3 Immune Thrombocytopenia Purpura

☐ M30.3 Kawasaki Disease

☐ L12.9 Pemphigoid, Unspecified

☐ L10.9 Pemphigus, Unspecified

☐ M33.2 Polymyositis

☐ Other _____

REQUIRED FOR HOME INFUSION RX to include diluents, needles, syringes, ancillary supplies, home medical equipment to administer infusion.

IV Access	**To be administered PERIPHERALLY, unless otherwise indicated.** ☐ PORT ☐ PICC	
Flush Protocol for IVIG drug admin days only	• 0.9% NaCl: 1-10mL IV before/after infusion, or PRN for line patency/SASH. • Heparin 10 units/mL: 5mL IV (peripheral) PRN for final flush. *For multi-day infusions • Heparin 100 units/mL: 5mL IV (central) PRN for final flush.	* For multi-day infusions, peripheral IV to be obtained, maintained, and discontinued for the duration of the infusion cycle per RN discretion in accordance with INS guidelines.
Pre and Post Medications Please strikethrough if not required	**To be given by mouth 30 minutes prior to infusion. May repeat every 4-6 hours as needed.** **Diphenhydramine** 25mg-50mg Adult max: 100mg/day **Acetaminophen** 325mg-650mg Adult max: 3000mg/day	***For subcutaneous patients only* if requested by patient/nurse.** **Lidocaine 2.5%/Prilocaine 2.5%** topical (may dispense Lidocaine 4%) to injection site(s) at least 1 hour prior to needle insertion.
Anaphylaxis Protocol	**To be given intramuscularly PRN severe allergic reaction. Call 911. May repeat x 1.** • Epinephrine 0.3mg (≥30kg/66lbs)	
Hydration Please select only if needed for IVIG	☐ 0.9% NaCl _____ mL infused over _____ minutes ☐ D5W _____ mL infused over _____ minutes Nurse to determine hydration rate if rate not provided above.	**To be infused pre-infusion, unless otherwise indicated.** ☐ Concurrent with Infusion ☐ Other _____
Diphenhydramine Please select only if needed	**To be given via slow IV push PRN for moderate – severe reaction.** ☐ 25-50mg ☐ Other _____	
Quantity and Refills	Dispense 1-month supply with 1-year refill unless indicated below. ☐ Dispense 3-month supply with 1-year refill ☐ Other _____	
Additional Orders		

PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

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.

☐ May Substitute/Product Selection Permitted/Substitution Permissible

Prescriber Signature _____ **Date** _____

☐ Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute

Prescriber Signature _____ **Date** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" **NY & Iowa** providers, please submit electronic prescription.

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