CarePartners Specialty Infusion

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

IMMUNOGLOBULIN (IG) IMMUNOLOGY 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

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

☐ Patient already trained on subcutaneous infusion

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

☐ Infuse _____ GRAMS daily for_____day(s), every _____ week(s)

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

_____ GRAMS/KG divided over_____ day(s), every _____ week(s)

-OR-

☐ 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

- ☐ 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
- ☐ D80.6 Antibody deficiency with near-normal immunoglobulins or with hyperimmunoglobulinemia
- ☐ D81.0 Severe Combined Immunodeficiency (SCID)
- ☐ D82.0 Wiskott-Aldrich Syndrome
- ☐ 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.

	Adult	6-12 years old	2-5 years old	<2 years old
Diphenhydramine	25mg-50mg max 100mg/day	12.5mg - 25 mg	6.25mg - 12.5mg	1mg/kg up to max 6.25mg
Acetaminophen	325mg-650mg max 3000mg/day	10-15mg/kg		

***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)
- Epinephrine 0.15mg (15kg to <30kg /33lbs to <66lbs)
- For IVIG only: Epinephrine ampule 0.1mg (7.5kg to <15kg /16.5lbs to <33lbs)

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 *For IV Adult Patients only* ☐ 1mg/kg/dose (Max dose 50mg) *For IV Pediatric Patients Only*

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.