SUBCUTANEOUS IMMUNE GLOBULIN REFERRAL FORM

Phone#: 877-778-0318 Fax#: 877-778-0399

Patient information

Patient Name: _____ DOB: _____
Sex: ❑ Female ❑ Male SS #: _____
1˚ Language: _____ Wt:_____ ❑ kg ❑ lbs Ht:_____ ❑ cm ❑ in
Address: _____
Apt/Suite: _____ City:_____ State:_____ Zip:_____
Phone:_____ Alternate Phone:_____
Caregiver name: _____ Relation: _____
Local Pharmacy: _____ Phone: _____

Prescriber + Shipping Information

Prescriber Name:_____
NPI #: _____
Address: _____
Apt/Suite: _____ City:_____ State:_____ Zip:_____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email address: _____
If shipping to presciber: ❑ 1st Fill ❑ Always ❑ Never

Insurance Information (Please fax a copy of front and back of the insurance cards)

1˚ Insurance Plan: _____ Plan ID # _____ Policy Holder: _____ Relation: _____
2˚ Insurance Plan: _____ Plan ID # _____ Policy Holder: _____ Relation: _____

Clinical Information (Please fax all pertinent clinical and lab information)

ICD-10/Diagnosis Code: _____
Date of Diagnosis: _____
IgA deficiency: ❑ Yes ❑ No IgA level _____ mg/dL Date:_____
IgG trough:_____mg/dL Date:_____ Diabetic: ❑ Yes ❑ No
Has patient received immune globulin previously? ❑ Yes ❑ No
If yes, product information: _____
Date of last infusion: _____ Date of next infusion: _____
Comorbidities: _____
Allergies: ❑ NKDA ❑ Other: _____

Prescription

Immune Globulin Products	❑ Hizentra® 20% *Weekly Sub-Q dose = IVIG Dose (g) x 1.37 / IVIG weekly interval originally given*
	❑ HyQvia® 10% Complete the MyIg source form at http://www.myigsource.com/pdf/Baxalta_Rx_Forms.pdf for orders and patient registration.
	❑ GammaKed™ 10% ❑ Gammagard liquid® 10% ❑ Gamunex-C® 10% *Weekly Sub-Q dose = IVIG Dose (g) x 1.53 / IVIG weekly interval originally given*
Therapy Regimen	Dose: _____ grams _____ times weekly # Doses: _____ Refill: _____ Administration rate and number of sites: ❑ Per manufacture guidelines, as tolerated ❑ _____
Other Medications	❑ Acetaminophen Take _____ mg by mouth every 4-6 hours as needed for fever and/or headache
	❑ Diphenhydramine Take _____ mg by mouth every 4-6 hours as needed for itching
	Drug: _____ Strength: _____ Qty: _____ Directions: _____ Refills: _____
Anaphylaxis Orders and Medications	Orders: 1. Stop infusion 2. Call 911 and prescribing physician 3. Administer medications below as per protocol
	❑ Epinephrine ❑ EpiPEN® - Administer 0.3 mg (1:1000) subcutaneously as needed (≥ 30 Kg or ≥ 66 lbs) ❑ EpiPEN Jr® - Administer 0.15 mg (1:2000) subcutaneously as needed (< 30 Kg or < 66 lbs) Qty: _____ Refill: _____
Ancillary Supplies	❑ As needed for proper administration and disposal of medication
Skilled Nursing Visits	❑ To train patient/caregiver in Subcutaneous Immune Globulin administration, provide education related to disease state/therapy and assess general status. Typically 3 training visits required. Once trained and able to return demonstrate, patient/caregiver to self-adminster Subcutaneous Immune Globulin medication independently

Administration procedures to be followed per pharmacy protocol.

Prescription will be filled with generic (if available) unless prescriber writes “DAW” (dispense as written): _____

Prescriber’s Signature:_____ Date: _____

I authorize Ameripharma Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.