

Subcutaneous Immune Globulin



31 Moody Rd. Enfield, CT 06082
 1111 Elm St. Ste 12 West
 Springfield, MA 01089
 Phone & Fax: 844-469-5933

Patient Information Prescriber + Shipping Information

| | |
|---|--|
| Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate Phone: _____ Caregiver name: _____ Relation: _____ Local Pharmacy: _____ Phone: _____ | Prescriber Name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email address: _____ If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never |
|---|--|

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

1st Insurance Plan: _____ Plan ID #: _____ Policy Holder: _____ Relation: _____

Clinical Information (Please fax all clinical and lab information)

Diagnosis Code(s): _____
 Date of Diagnosis: _____ Has patient received immune globulin previously? Yes No
 IgA deficiency: Yes No IgA level _____ mg/dL Date: _____ If yes, product information: _____
 IgG trough: _____ mg/dL Date: _____ Diabetic: Yes No Date of last infusion: _____ Date of next infusion: _____
 Comorbidities: _____
 Concomitant Medications: _____
 Allergies: NKDA Other: _____

Prescription Drug Dose and Directions Quantity Refills

| Prescription | Drug | Dose and Directions | Quantity | Refills |
|--------------------------|---|--|----------|---------|
| Immune Globulin Products | <input type="checkbox"/> Cuvitru 20% | <input type="checkbox"/> _____ Number of sites: _____ Rate: <input type="checkbox"/> Per manufacture guidelines, as tolerated _____ <i>Weekly SC dose = IVIG Dose (g) x 1.3 / IVIG weekly interval originally given</i> | _____ | _____ |
| | <input type="checkbox"/> Hizentra® 20% | <input type="checkbox"/> _____ Number of sites: _____ Rate: <input type="checkbox"/> Per manufacture guidelines, as tolerated <input type="checkbox"/> _____ <i>Weekly SC dose = IVIG Dose (g) x 1.37 / IVIG weekly interval originally given</i> | _____ | _____ |
| | <input type="checkbox"/> Gammaked™ 10% <input type="checkbox"/> Gammagard liquid® 10% <input type="checkbox"/> Gamunex-C® | <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ Number of sites: _____ Rate: <input type="checkbox"/> Per manufacture guidelines, as tolerated _____ <i>Weekly SC dose = IVIG Dose (g) x 1.37 / IVIG weekly interval originally given</i> | _____ | _____ |
| | <input type="checkbox"/> HyQvia® 10% | Please complete and attach HyQvia Prescription Referral form which can be located at: http://www.hyqviahcp.com/pdf/PatientRxStartForm.pdf | | |

Other Medications
 Acetaminophen _____ mg Premedication 30 minutes prior to infusion. Post infusion every 4-6 hours as needed for fever/headache.
 Diphenhydramine _____ mg Premedication 30 minutes prior to infusion. Post infusion every 4-6 hours as needed for itching/site reactions.
 Lidocaine 2.5% and Prilocaine 2.5% Cream 30 grams. Apply small amount topically to insertion site(s) prior to needle insertion as needed.
 Drug: _____ Strength: _____ Quantity to dispense: _____
 Directions: _____ Refills: _____

The quantity and refills for pre-treatment and flushing protocol medications will match the primary therapy administration requirements.

Anaphylaxis Order and Medication
 Orders: 1. Stop infusion 2. Call 911 and prescribing physician 3. Administer medications below as per protocol
 Epinephrine Auto-injector Administer 0.15 mg (15 - 30 kg) IM or subcut as needed
 Administer 0.3 mg (≥ 30 kg) IM or subcut as needed
 Quantity: 2 Refills: _____

Supplies & Equipment
 Syringe driver/pump(s) and supplies provided as needed for administration and appropriate disposal of infusion materials.

Skilled Nursing Visits
 To train patient/caregiver in Subcutaneous Immune Globulin administration, provide education related to disease state/therapy and assess general status. Typically 2-4 training visits required. Once trained and able to return demonstrate, patient/caregiver to self-administer Subcutaneous Immune Globulin medication independently unless otherwise specified.

Prescriber's Signature: _____ Date: _____

I authorize Mylyfe Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Mylyfe Pharmacy.

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