SpecialtyCareRx

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IV/SQ Ig Referral Form

Patient Information	Prescriber Information
Patient Name: ____________________________ DOB: __/__/____	Prescriber Name: ___________________ NPI: ___________
Sex: □ Femal □ Male SS#: ___-__-____ Language: ______	If Shipping to prescriber: □ Initial Fill □ Always □ Never
Allergies: ______________ Wt: ____ □Kg □Lb Ht: ____ □Cm □In	Addess: ____________________________ Apt/Suite: ______
Addess: _________________________________ Apt/Suite: ________	City: __________________ State: ________ Zip________
City: __________________ State: ___________ Zip: ____________	Phone: ________________ Contact: ____________________
Phone: _______________ Contact: _________ Relation: ________	Fax: ______________ Alt. Fax: ____________________
Email Address: ____	Email Address: ______________________________________

INSURANCE INFORMATION (or attach copy of cards)

Medical Plan: ________________ Policy #: __________ Policy Holder: _______________ Relationship: _______________

Prescription Plan: _____________ Policy #: __________ Policy Holder: _______________ Relationship: _______________

Clinical Information

Access Type: □ Peripheral □ PICC □ PORT □ SCIG

Has patient previously been on IG therapy? □ No □ Yes/Brand Infused:___________/Last Infusion:__________

Comorbidities/Risk Factors: □ Renal Insufficiency □ Diabetes □ Heart Disease □ Thromobotic Event □ Hypertension

IgA deficiency: □ Yes □ No IgA level:_____mg/dL (Date:________) Does patient have a latex allergy? □ Yes □ No

Previously Tried Treatments/Medications for The Condition: ____

Prescription

□ IVIG (Pharmacy to determine)		□ SQIG (Pharmacy to determine)
□ Cutaquig 16.5% (SC route)	□ Gammaked 10%	□ Octagam 5% 10%
□ Cuvitru 20% (SC route)	□ Gamunex-C 10%	□ Panzyga 10%
□ Gammagard Liq 10%	□ Hizentra 20% □PFS □Vials (SC route)	□ Privigen 10%
□ Gammagard S/D □5% □10%	□ HyQvia 10% (SC route)	□ Xembify 20% (SC route)
□ Other: _______________		

Dose and Frequency

□ Intravenous Immunoglobulin	□ Subcutaneous Immunoglobulin

□ Loading Dose: ____ gm/kg Over ____ day(s) then

□ Maintenance Dose: ____ gm/kg Over ____ day(s), every ____ week(s) X ____ cycle(s)

□ 0.4 gm/kg □ 1 gm/kg □ 2 gm/kg	□ Infuse ____ grams OR ____mLs
□ Infuse ____ grams IV daily X ___ day(s); repeat every week(s) X ___ cycle(s)	using ___ sites X ___ time(s) per week
□ Other: ____	for ___ month(s)

Hydration and Pre-Medications

□ Hydration: NaCl 0.9% 250mL to infuse at a rate of 250mL/hr IV before & after infusion as hydration is needed.

□ Benadryl 25mg capsule: Take 1-2 caps by mouth 30-60 minutes prior to infusion & every 6 hours as needed post infusion.

□ Benadryl 50mg ampule: Infuse ____mg slow IVP 30 minutes prior to infusion

□ Tylenol 325mg: Take 1-2 tabs by mouth 30-60 minutes prior to infusion & every 6 hours as needed post infusion.
Not to exceed total daily dose of 3000mg.

□ Zofran 4mg ODT: Dissolve 1 tab on the tongue every 8 hours as needed for pre & post infusion for nausea and vomiting.

□ Solu-Cortef: Infuse _____mg slow IVP 30 minutes prior to infusion

□ Solu-Medrol: Infuse _____mg slow IVP 30 minutes prior to infusion

Flushing Protocol
□ Sodium Chloride 0.9% 5-10 ml pre and post medications □ Heparin ____Units/mL OR ____mL as needed
Anaylaxis Protocol
MILD infusion reactions: (Slow infusion rate by 50% until symptoms resolve. Resume at previous rate as tolerated) Diphenhydramine 25mg caps #4 Sig:Take 1-2 capsules PO Q6H PRN for infusion reactions, NTE total daily dose of 400mg (16 caps/day). **MODERATE infusion reactions: (Stop Infusion, resume at 50% rate when symptoms resolve)** Diphenhydramine 50mg/ml vial #1 Sig: Inject 1ml (=50mg) IV by slow IV push over 3-5 mins PRN for anaphylaxis reaction. May repeat every 4 hrs, NTE 400mg/24hrs **SEVERE ANAPHYLAXIS *CALL 911* (Stop infusion and remove tubing from access device to prevent further administration)** 1. Epinephrine 0.3mg Auto Injector #2 Sig: Remove cap then inject auto-injector intramuscularly in the thigh area and hold for 2 to 10 seconds as needed for anaphylaxis reaction, may administer through clothing if necessary. May repeat in 5-15-minutes. 2. Initiate 0.9% NaCl 500 mL IV x 1 3. Administer CPR if needed until EMS arrives
Ancillary Supplies : As needed for proper administration and disposal of medication
Skilled Nursing Visits: As needed for IV access, administration and proper clinical monitoring
Administration procedures to be followed per pharmacy protocol.
Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): _______
Deliver to: □ Home □ Office □ Infusion Suite □ Other: __________ If shipped to prescriber's office or infusion clinic, prescriber accepts on behalf of patient for administration in office or infusion clinic. By signing this order, I, the prescriber, certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.
Prescriber's Signature ____________________ **Date: ___/___/_____**
* Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient’s choice or in the patient’s insurer’s provider network.