Clinical Specialty Infusions, LLC

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IMMUNE GLOBULIN ENROLLMENT FORM – IMMUNOLOGY

Account manager: _____ **Contact info:** _____

✂ AZ: Please detach before submitting to a pharmacy.

PATIENT INFORMATION

Patient Name:		Patient/Caregiver (if applicable):	
Address:	City:	State:	Zip:
Main phone: / Alternate phone:	Email:	Last 4 of SSN (required):	
Date of birth: / ☐ Male or ☐ Female	Height (required): ☐ cm or ☐ inches	Weight (required): ☐ lb or ☐ kg	
Is this the FIRST dose of Ig? ☐ Yes or ☐ No	Prior Ig product(s) used:		
Allergies:	Current medications:		

Please include face sheet, copy of insurance cards (front and back), H&P, clinicals, and any available lab results.

CLINICAL INFORMATION – PRIMARY DIAGNOSIS ICD-10

- ☐ D80.0 - Hereditary hypogammaglobulinemia
- ☐ D80.2 - Selective deficiency of immunoglobulin A [IgA]
- ☐ D80.3 - Selective deficiency of immunoglobulin G [IgG] subclasses
- ☐ D80.4 - Selective deficiency of immunoglobulin M [IgM]
- ☐ D80.5 - Immunodeficiency with increased immunoglobulin M [IgM]
- ☐ D81.1 - Severe combined immunodeficiency with low T- and B-cell numbers
- ☐ D81.2 - Severe combined immunodeficiency with low or normal B-cell numbers
- ☐ D81.89 - Other combined immunodeficiencies
- ☐ D81.9 - Combined immunodeficiency, unspecified
- ☐ D82.0 - Wiskott-Aldrich syndrome
- ☐ D82.1 - Di George's syndrome
- ☐ D82.4 - Hyperimmunoglobulin E [IgE] syndrome
- ☐ D83.9 - Common variable immunodeficiency, unspecified
- ☐ Other: _____

PRESCRIPTION AND ORDERS

Specific IG product, if desired (Pharmacist will choose appropriate product for patient if left blank): _____

Route: ☐ Intravenous ☐ Subcutaneous	**Frequency**: ☐ Every 4 weeks ☐ Every _____ weeks	**Dispense**: ☐ 1 month **Refills** x _____	**Supplies**: Dispense ancillary supplies as needed to provide home infusion therapy, including ambulatory pump and associated supplies.
Dosing: ☐ 0.4 g/kg ☐ 1.0 g/kg ☐ _____ g/kg	**Access**: ☐ Peripheral ☐ PICC ☐ Port ☐ Other: _____	**Orders**: ☐ Clinical Pharmacist to dose and send orders for review/signature. **Labs**: CBC and CMP with each infusion, OR _____	

Pre-Treatment: Dispense quantity sufficient
- Acetaminophen 500mg tab: 1-2 tablets by mouth 15-30 min prior to infusion
- Diphenhydramine 25mg tab: 1-2 tablets by mouth 15-30 min prior to infusion
- Hydration: NS 0.9% 100-500 mL IV over 30 min before each infusion, as needed

Adverse/Anaphylactic Reactions, per protocol:
- Epinephrine 1:1000, 1 mL ampule OR EpiPen 2pack
- Diphenhydramine 25mg tab #2
- Sodium Chloride 0.9% 1000 mL Bag #1
- Diphenhydramine 50mg/1mL vial #1

Nursing Orders for Home Infusion: MONITOR (IV only)
Observe: Vital signs prior to infusion. Blood pressure and pulse every 15 minutes for first hour, then every 30 minutes until stable infusion rate, then every hour. Watch for: Signs of fluid overload, cardiovascular symptoms, allergic reactions, skin rash, fever, and moderate to severe headache.

PRN Orders:
- ☐ Ondansetron 4mg slow IVP as premed for infusion induced nausea
- ☐ Toradol 15mg-30mg SIVP as premed for infusion induced headache or muscle pain
- ☐ Methylprednisolone 1 mg/kg (12.5 - 125 mg) slow IVP as pre-med or PRN for infusion-related cutaneous reaction or headache
- ☐ Other: _____

PRESCRIBER INFORMATION

Physician name:		Practice site name:	
Address:	City:	State:	Zip:
NPI:	Phone:	Fax:	

Office contact and special instructions:

* **Prescriber Authorization:** I authorize the 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.

Prescriber's signature: Date:

Immune Globulin Pre-authorization Checklist

Help us speed authorization for treatment.

Please use this checklist to ensure all necessary documentation is submitted to support initial authorization of immune globulin (IG) therapy:

Autoimmune Disorders

- Completed referral form
- Insurance information (copy of insurance card/s preferred)
- Recent progress notes (two or more)
- Labs or diagnostic evidence supporting indication (e.g., electromyography, nerve conduction velocity, spinal tap or lumbar puncture, MRI, nerve and/or muscle biopsy, antibody testing)
- History of failure, contraindication or intolerance to other treatments (e.g., ace inhibitors, prednisone, azathioprine)

Primary Immunodeficiencies

- Completed referral form
- Insurance information (copy of insurance card/s preferred)
- Recent progress notes (two or more)
- History of failure with antibiotic treatment
- Pre-treatment IgG, IgA, IgM, and Ig subclass serum levels
- Current IgG, IgA, IgM, and IgG subclass serum levels
- Pre- and post-vaccine titers showing impaired antibody response to vaccine trial with pneumococcal, H influenza type B, or tetanus/diptheria (measured 3-4 weeks after administration)