CSI CLINICAL SPECIALTY INFUSIONS

Phone: 833-569-1005 | Fax: 430-200-4889 | Online: deliver.myforcura.com

IMMUNE GLOBULIN ENROLLMENT FORM - AUTOIMMUNE

Account manager: _____ Contact info: _____

✂ AZ: Please detach before submitting to a pharmacy.

PATIENT INFORMATION

Patient Name:		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

CLINICAL INFORMATION

Primary ICD-10 Code:	Is patient currently on therapy? ☐ Yes or ☐ No	Previous tried/failed therapies:
Allergies:	Current medications:	

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

PRIMARY DIAGNOSIS ICD-10

☐ G25.82 - Stiff-person syndrome
☐ G35 - Multiple sclerosis (MS)
☐ G61.0 - Acute infective polyneuritis (Guillain-Barré syndrome)
☐ G61.81 - Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
☐ G61.82 - Multifocal motor neuropathy (MMN)
☐ G61.89 - Inflammatory polyneuropathy, unspecified
☐ G70.00 - Myasthenia Gravis without (acute) exacerbation
☐ G70.01 - Myasthenia Gravis with (acute) exacerbation
☐ L10.0 - Pemphigus (pemphigus foliaceus, pemphigus vulgaris)
☐ L12.0 - Pemphigoid
☐ M33.10 - Dermatomyositis
☐ M33.20 - Polymyositis
☐ Other: _____

PRESCRIPTION AND ORDERS

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

Route: ☐ Intravenous ☐ Subcutaneous

Access: ☐ Peripheral IV ☐ Port
(may attempt PIV if unable to access PORT)

IVIG Dosing (standard autoimmune):
☐ Initial = 2 g/kg IV over 2-5 days
☐ Ongoing = 1 g/kg IV every 3 weeks OR ☐ 2 g/kg every 4 weeks
☐ Ongoing = _____g/kg IV every _____weeks

SCIG Dosing:
_____ grams subcutaneously weekly
_____ g/kg per month subcutaneously - divided into weekly doses

Dispense: ☐ 4-week supply ☐ Other: _____

Refills: x 1 year unless noted otherwise: _____refills

Supplies: Dispense ancillary supplies, including ambulatory infusion pump or subcutaneous infusion pump.

Medication Specific Infusion and Administration:
IVIG: Infusion rate titrated based on the individual product and patient tolerability. Clinical Pharmacist to adjust rates as clinically indicated. Nursing refer to prescription label for patient specific infusion rates.
SCIG: Infusion rate as detailed in the package insert and adjusted for patients weight and tolerability. Clinical Pharmacist to adjust rates as clinically indicated. Nursing refer to prescription label for patient specific infusion rates.

Labs:

Premedication 30 minutes prior to infusion:
☐ Acetaminophen 325-1000 mg PO, dispense x 1 bottle (refill x 1 year)
☐ Diphenhydramine 25-50 mg PO, dispense x 1 bottle (refill x 1 year)

Adverse/Anaphylactic Reactions, per protocol (Subcutaneous):
- Epinephrine autoinjector 0.3 mg IM as directed PRN for anaphylaxis, dispense 2pk x 1 (refill x 1 year)

Adverse/Anaphylactic Reactions, per protocol (Intravenous): dispense ana-kit x 1 (refill x 1 year)
- Epinephrine 1:1000, 1 mL vial x 1
- Diphenhydramine 50 mg/1 mL vial x 1
- Diphenhydramine 50 mg tab/cap x 1
- 0.9% Sodium Chloride 500 mL bag x 1

PRN:
☐ Lidocaine/Prilocaine 2.5% apply to site of injection as needed for numbing effect. Remove prior to injection, dispense 30 g tube (refill x 1 year)
☐ Methylprednisolone 1 mg/kg (12.5-125 mg) slow IV push once as PRN for infusion-related cutaneous reaction or headache (IVIG infusions ONLY), dispense x 1 dose (refill x 1 year)
☐ Ondansetron 4-8 mg slow IV push once as pre-med for nausea, then every _____hours x_____post-infusion (IVIG infusions ONLY), dispense x 2 doses (refill x 1 year)
☐ Other: _____

Nursing Orders for Home Infusion: Provide skilled nursing for home medication administration as prescribed and per CSI nursing policies. Insert, access, and manage vascular access devices. Deliver nursing care for therapy duration and educate patient on medication, disease state, adverse reactions, and administration. Monitor patient response and report adverse events. Additional teaching visits may be required for self-administration.

Flush Orders (IV infusions ONLY): Flush with 0.9% sodium chloride 5-10 mL pre and post medication and as needed, max per dispense x 60 syringes (refill x 1 year). For CVADs ONLY, may add Heparin 3-5 mL as final flush to maintain patency as needed; PORT 100 units/mL; PICC 10 units/mL, max per dispense x 30 syringes (refill x 1 year).

PRESCRIBER INFORMATION

Prescriber 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:**

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Autoimmune Disorders 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, PLEASE INCLUDE ON BEHALF OF THE PATIENT (IF AVAILABLE):

- Completed referral form
- Insurance information (copy of insurance card/s preferred)
- Last two office visit notes to include current symptoms and tried/failed therapies
- Labs or diagnostic evidence supporting indication (e.g., EMG/NCS, spinal tap or lumbar puncture, MRI, nerve and/or muscle biopsy, antibody testing, Skin/Punch Biopsy)
- History of failure, contraindication or intolerance to other treatments (e.g., PLEX, corticosteroids, immunosuppressants)

ADDITIONAL HELPFUL CLINICAL INFORMATION IF AVAILABLE:

Stiff Person Syndrome

- EMG/NCS
- Anti-GAD, Anti-GM1 Antibody Lab (if done)
- T/F therapies (immunosuppressants, corticosteroids, benzodiazepines and muscle relaxants)

Multiple Sclerosis (Relapsing Form)

- MRI
- CSF (if done)
- Documentation of MS exacerbation or progression of symptoms despite:
- T/F therapies (specifically oral and injectable MS agents)

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) or Guillan-Barre Syndrome (GBS)

- EMG/NCS
- T/F therapies (immunosuppressants, corticosteroids)
- LP with elevated CSF protein and normal WBC (if done)

Multifocal Motor Neuropathy (MMN)

- EMG/NCS
- Anti-GM1 Antibody Lab (if done)
- T/F therapies (immunosuppressants, corticosteroids)

Peripheral and Small Fiber Neuropathy

- EMG/NCS (if done)
- Nerve/Skin biopsy
- Antibody testing (if done)
- T/F therapies (immunosuppressants, corticosteroids)

Myasthenia Gravis (MG) (with or without acute exacerbation)

- Tensilon Test (if done)
- MG-ADL score worksheet, documentation of current condition (shortness of breath, swallowing difficulty, overwhelming fatigue, etc.)
- T/F therapies (immunosuppressants, corticosteroids)
- Lab Work/Antibody testing
- Recent (within the last month) chart notes documenting symptoms of exacerbation (if applicable).

Polymyositis/Dermatomyositis/Necrotizing Myopathy

- Muscle biopsy
- EMG/NCS (if done)
- T/F therapies (immunosuppressants, corticosteroids)
- Labs (if completed): Serum CK, Myositis panel