CSI CLINICAL SPECIALTY INFUSIONS

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

IMMUNE GLOBULIN ENROLLMENT FORM - IMMUNOLOGY

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

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.

PRIMARY DIAGNOSIS ICD-10

☐ D80.0 Hereditary hypogammaglobulinemia
☐ D80.1 Nonfamilial hypogammaglobulinemia
☐ D80.3 Selective deficiency of immunoglobulin G [IgG] subclasses
☐ D80.6 Antibody deficiency with near-normal immunoglobulins or with hyperimmunoglobulinemia
☐ 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
☐ D83.0 Common variable immunodeficiency with predominant abnormalities of B-cell numbers and function
☐ D83.2 Common variable immunodeficiency with autoantibodies to B- or T-cells
☐ 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

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

IVIG Dosing:
☐ 0.4 g/kg IV every 4 weeks
☐ _____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 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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Immunology 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:

IMMUNOLOGY 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
- History of failure with antibiotic treatment
- Labs or diagnostic evidence supporting indication
- Pre-treatment IgG, IgA, IgM, and IgG 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)

PRIMARY IMMUNODEFICIENCIES

Non-Familial Hypogammaglobulinemia

- History of recurrent sinusitis, bronchitis, and/or pneumonia
- Blood work/testing with documented low IgG levels

Congenital Hypogammaglobulinemia

- History of recurrent sinusitis, bronchitis, and/or pneumonia
- Blood work/testing with documented low IgG levels lower than 200mg/dl, low or absent B cells

Selective Antibody Deficiency

- History of recurrent sinusitis, bronchitis, and/or pneumonia
- Blood work/testing with documented IgG levels normal or low and vaccine challenge (pre titers and post titers drawn 4 weeks after)

Selective IgG Subclass Deficiency

- History of recurrent sinusitis, bronchitis, and/or pneumonia
- Blood work/testing with documented IgG levels normal, IgG subclasses low and vaccine challenge (pre titers and post titers drawn 4 weeks after)

Severe Combined Immunodeficiency (SCID)

- History of bone marrow transplant (if applicable)
- Blood work/testing with documented low or absent IgG, IgA, IgM, IgG Subclasses

Common Variable Immunodeficiency (CVID)

- History of recurrent sinusitis, bronchitis, and/or pneumonia
- Blood work/testing with documented low IgG levels and vaccine challenge (pre titers and post titers drawn 4 weeks after)
- CBC with differential including B and T Cell panel