

Referral prescription — Subcutaneous immune globulin (IG)

Fax form to 1 866 233-7151

Please complete information below. Have prescriber sign, and fax this form and the requested documents to 1 866 233-7151.

1 PRESCRIBER INFORMATION

Prescriber name _____

Full name and title of person faxing this form _____

Address _____

Office contact _____

Phone _____ Fax _____

License # _____ NPI # _____

Diagnosis: Congenital hypogam 279.04 Common variable immune deficiency 279.06
 Severe combined immunodeficiency 279.2 Other _____

2 PATIENT INFORMATION

*Please fax front and back copy(s) of patient's insurance card(s) and clinical notes justifying the need for IG.

Patient name _____

Date of birth _____ Male Female Last 4 digits of SSN _____

Patient weight _____ Allergies _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Parent/guardian (if applicable) _____

Home phone _____ Work phone _____

Cell phone _____ Evening phone _____

E-mail address _____

Primary insurance company name _____

Primary insurance company phone # _____

Insured name _____ Relationship to patient _____

Insured employer _____

Identification # _____ Policy/Group # _____

Secondary insurance company name _____

Secondary insurance company phone # _____

Insured name _____ Relationship to patient _____

Insured employer _____

Identification # _____ Policy/Group # _____

For questions, please contact **Accredo**.

Phone: toll-free 1 866 820-IVIG (1 866 820-4844) Fax: 1 866 233-7151

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3 PRESCRIBING INFORMATION

Immune globulin product: (check one product listed below):

- Gammagard*® liquid 10% *Gammaked*® 10% *Gamunex*®-C 10% *Hizentra*® 20%
 Other _____

Dose _____ mg per kg (rounded to nearest vial size) **OR** _____ gm to be administered subcutaneously

Frequency _____ day(s) per week **OR** daily for _____ day(s) every _____ week(s).

Infuse total dose of immune globulin divided over 1-4 subcutaneous sites simultaneously, as appropriate. Administer over 1-2 hours via infusion pump.

Refills (# or through date) _____

Premedications

(Oral medications may be given orally 30 minutes prior to infusion and every 4-6 hours prn)

- Diphenhydramine 25-50 mg PO for chills, rash, or itching; max 4 doses a day
 Acetaminophen 325-650 mg PO for fever, headache, or chills; max 4 doses a day
 Other: Lidocaine-based cream 2.5%-4% (Applied topically to site for subcutaneous needle insertion, if needed)
 Other _____

Adverse reaction medications (to be maintained in the patient's home and administered as necessary)

- EpiPen*® 0.3 mg for greater than 30 kg pt weight or *EpiPen Jr.*® 0.15 mg for less than 30 kg pt weight IM prn severe anaphylactic reaction times one dose
 Diphenhydramine 25-50 mg PO as needed for adverse reaction if able to swallow

Supplies (Please strike through if not required.):

- Dispense 28 days of medication, needles, syringes, ancillary supplies, and home medical equipment necessary to administer medication.

Accredo nursing services (Please strike through if not required.):

- Skilled nursing visits to educate patient on subcutaneous access, medication administration, use of supplies, therapy, and disease state and to assess general status and response to therapy. Patient discharged from nursing once teaching complete.

By signing below, I certify that the above therapy is medically necessary.

Prescriber's printed name _____

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Prescriber's signature (sign below) _____ **Date** _____

Dispense as written

(Prescriber attests this is his/her legal signature. **NO STAMPS**)

Substitution allowed