Please fax all pages of completed form to your team at 808-650-6487.

To reach your team, call toll-free 808-650-6488.

Prescription & Enrollment Form Immune Globulin



Four simple steps to submit your referral.

1 Patient Information		rovide copies of front and back of all medical cription insurance cards.
Patient's first name	Last name	Middle initial
Sex at birth: Male Female Pronouns	Last 4 digits of SSN	Date of birth
		Apt #
		Zip
Parent/guardian (if applicable)		Email address
2 Prescriber Informatio	n All fields must be	e completed to expedite prescription fulfillment.
Prescriber's first name	Last name	
_icense #	NPI #	
		Suite #
		Zip
		License #
	Fax	
3 Clinical Information		
Home infusion Clinic infusion	kg/lbs Date weight obtained dose due	
CD-10 Diagnosis Code (Required): ICD-10 immunology: D80.0 Cong ICD-10 neurology: G61.81 CIDP ICD-10 rheumatology: M33.20 Po	olymyositis M33.90 Dermatomyositis	D81.9 SCID (unspecified) G61.0 GBS G70.01 MG
Allergies		
	Complete RX information on Page	2

_____ Last name _

Patient's first name _

ONE

Middle initial _____ Date of birth ___

	list preferred brand be g clinical information, nds are clinically appr	, insurance requirements a ropriate for the patient. A	and brand credo will	availability. By signing "SUBSTITUTION communicate to you the brand selected	N ALLOWED" you
Route: Subcutaneous Intravenous Brand: Pharmacist to select brand Prescriber's preferred brand listed below (required for Medicare B):	Infuse g Once weekly Other frequency	,	g per kg 4 weeks	If subcutaneous: Infuse total dose of subcutaneously in 1 to multiple subcutanifusion pump as tolerated. Infusi manufacturer recommendation as tolerated.	utaneous sites on rates per
If Intravenous: Titrate initial and maintenan manufacturer's product labeling. Vascular access: Peripheral Central Infusion method: Gravity Pump	ce infusion rates per Port	Infuse 500mL of 0.	9% Norma	Il Saline intravenously prior to infusion nously given concurrent with IVIG at sa	
Premedications to be given 30 minutes pri Diphenhydramine 25mg by mouth for mild myasthenia gravis) For pediatric patients the following weight a ≤9kg and/or <2 years old: 1mg/kg up to ma Acetaminophen 650mg by mouth (For pedi Other Medications to be used as needed (strike t Diphenhydramine 25mg by mouth every 4-6	infusion reactions, mand aged based dosin x of 6.25mg, 2-5 yea atric patients weighin hrough if not require	nay increase to 50mg for any range will be used for a pars old and >9kg: 6.25mg less than 60kg: Acetan ed):	nistory of r II Diphenh g to 12.5m ninophen	nydramine prescribed: ng, 6-12 years old: 12.5mg to 25mg 10-15mg/kg by mouth for all Acetamir	nophen prescribed)
oper day (contraindicated in patients with my Lidocaine 4% applied topically to insertion Acetaminophen 650mg by mouth every 4-6 Adverse event medications (Keep on hand Epinephrine 0.3mg for patients weighing \$\ince{2}\$	vasthenia gravis) site prior to needle in 5 hours as needed for at all times; Accredo	nsertion as needed to pre r fever, headache or chills o will provide an epineph	vent site p ; maximur rine auto i	ain n of 4 doses per day njector with the first subcutaneous fil	II only):
anaphylactic reaction times one dose Diphenhydramine 25mg by mouth for mild a Flushing for Intravenous: 0.9% Normal Sa				ous (central line/port) before and afte	er infusion, or as
needed for line patency Heparin 10 units per mL 3mL intravenous Heparin 100 units per mL 5mL intravenou					
Supplies: Dispense needles, syringes, ancil Quantity/Refills: Dispense 1 month supply. Refill x 1 year un Other			cessary to	administer medication.	
Skilled Nursing: IVIG- Visit as needed to est nursing visits to educate patient on subcuta and response to therapy. Patient to be disch	neous access, medic	cation administration, use			
shipped to physician's office or infusion cli "Pharmacist to select brand" option c	hosen above, sign	the "SUBSTITUTION A	LLOWED	" line below.	
rescriber's signature required (sign bel	ow) (Physician at	ttests this is his/her leg	al signat	ure. NO STAMPS)	SIGN
ate Dispense as written		 Date		Substitution allowed	HERE

accredo*

Non-compliance with state-specific requirements could result in outreach to the prescriber.

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. All rights in the product names, trade names or logos of all third-party products that appear in this form, whether or not appearing with the trademark symbol, belong exclusively to their respective owners. © 2024 Accredo Health Group, Inc. I An Express Scripts Company. All rights reserved. IGL-00113-100724 CRP1310412

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc.



Prior authorization checklist Primary immune deficiency disease (PIDD)

Providing Accredo with the documentation outlined in this checklist may increase the likelihood and speed of obtaining coverage for your patients with PIDD. Coverage criteria may vary by payer.

Refe	Referral form¹ (not required for electronic prescriptions)			
	Completed Immunoglobulin (Ig) referral form (available at accredo.com)			
	Copies of the front and back of all medical insurance and prescription benefits cards			
Clini	Clinical documents			
	History and Physical (H&P) and progress notes (within past 6 months) Note: H&P to include documented infection history/treatment			
	Pre-treatment IgG, IgA, IgM, and Ig subclass serum levels (drawn on two different occasions when available) Current IgG, IgA, IgM, and Ig subclass serum levels			
	Pre- and post-antigen testing (tetanus, pneumococcal polysaccharide or H Influenza type B) AND documentation of vaccine administration date			

D81.0 - Severe combined immunodeficiency	D82.0 - Wiskott-Aldrich syndrome	
(SCID) with reticular dysgenesis	D82.1 – Di George's syndrome	
D81.1 – Severe combined immunodeficiency		
(SCID) with low T- and B-cell numbers	D82.4 - Hyperimmunoglobulin E (IgE) syndrome	
D81.2 – Severe combined immunodeficiency (SCID) with low or normal B-cell numbers	D83 – Common variable immunodeficiency (CVID)	
D81.5 - Purine nucleoside phosphorylase (PNP) deficiency	D83.0 - CVID with predominant abnormalities of B-cell numbers and function	
D81.6 - Major histocompatibility complex class I deficiency	D83.1 – CVID with predominant immunoregulatory T-cell disorders	
D81.7 - Major histocompatibility complex class II deficiency	D83.2 - CVID with autoantibodies to B- or T-cells	
D81.89 – Other combined immunodeficiencies	D83.8 - Other CVIDs	
D81.9 - Combined immunodeficiency, unspecified	D83.9 - CVID, unspecified	
D82 – Immunodeficiency associated with other major defects	G11.3 - Cerebellar ataxia with defective DNA repair	
	(SCID) with reticular dysgenesis D81.1 - Severe combined immunodeficiency (SCID) with low T- and B-cell numbers D81.2 - Severe combined immunodeficiency (SCID) with low or normal B-cell numbers D81.5 - Purine nucleoside phosphorylase (PNP) deficiency D81.6 - Major histocompatibility complex class I deficiency D81.7 - Major histocompatibility complex class II deficiency D81.89 - Other combined immunodeficiencies D81.9 - Combined immunodeficiency, unspecified D82 - Immunodeficiency associated	

Fax completed form to 866.233.7151.

If you have any questions, please call your Accredo Provider Support Advocate, or call 866.820.4844.

1. For referral forms visit accredo.com.



Prior Authorization Checklist Neuromuscular Disorders¹

Providing Accredo with the documentation outlined in this checklist may increase the likelihood and speed of obtaining coverage for your patients. Coverage criteria many vary by payer.

Refe	Referral Form (not required for electronic prescriptions)			
	Completed Immunoglobulin (Ig) referral form (available at accredo.com)			
	Copies of the front and back of all medical insurance and prescription benefits cards			
Clin	Clinical Documents			
	History and Physical (H&P) and progress notes ² (within past 6 months) Note: Diagnosis of the disorder must be unequivocal			
	Documentation that other causes of demyelinating neuropathy have been excluded			
	Testing documentation: □ Electrophysiological motor-sensory nerve conductions □ Electromyography (EMG) □ Cerebrospinal fluid (CSF) □ Biopsy (muscle-nerve) - if necessary			

Add	Additional Requirements for Myasthenia Gravis			
	Tensilon test results			
	Refractory to corticosteroids over a 6 month period documentation			
	Ongoing Ig treatment must be documented in H&P and progress notes ²			
Additional Requirements for Polymyositis and Dermatomyositis Diagnosis				
	Creatine phosphokinase (CPK) values			
	Electromyography (EMG) and/or muscle biopsy results			

Fax completed form to 866.233.7151.

If you have any questions, please call your Accredo Provider Support Advocate, or call 866.820.4844.

¹ This Neuromuscular Disorders checklist is based on Medicare Part B guidelines related to Guillain-Barre' syndrome (GBS), relapsing-remitting multiple sclerosis, chronic inflammatory demyelinating polyneuropathy (CIDP) (and variant syndromes such as Multifocal Motor Neuropathy (MMN)), myasthenia gravis, refractory polymyositis, and refractory dermatomyositis, and refractory dermatomyositis

² Ongoing management and documentation requirements:

[·] Initial improvement and continued need must be meticulously documented in progress notes

[·] All weaning must be attempted and documented as either amount or frequency

[·] Must be a stoppage in IVIG if sustained improvement is noted with weaning or no improvement has taken place at all