

Please fax both pages of completed form to your drug therapy team at 866.233.7151.

To reach your team, call toll-free 866.820.IVIG (866.820.4844).

Prescription & Enrollment Form

Intravenous immune globulin (IVIG)

accredo[®]

Four simple steps to submit your referral.

Do not contact patient, benefits check only

1 Patient Information

New patient Current patient

Patient's first name _____ Last name _____ Middle initial _____

Male Female Date of birth _____ Street address _____

Apt # _____ City _____ State _____ Zip _____

Parent/guardian (if applicable) _____ Phone _____

Patient's primary language: English Other If other, please specify _____



Please attach copies of front and back of patient's insurance cards.

Insurance Company _____ Phone _____

Identification # _____ Policy/group # _____

Prescription card: Yes No If yes, carrier _____ Policy #: _____ Group # _____

2 Prescriber Information

Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office contact and title _____ Street address _____

Suite # _____ City _____ State _____ Zip _____

Phone _____ Fax _____ NPI # _____ License # _____

Infusion location: Infusion clinic Office Patient's home

If infusion clinic, address: _____

3 Clinical Information

CHECK ONE

ICD-10 immunology: D80.0 Congenital Hypogam D83.9 CVID (unspecified) D81.9 SCID (unspecified)

ICD-10 neurology: G61.81 CIDP G61.82 MMN G35 MS (rel remit) G61.0 GBS G70.01 MG

ICD-10 rheumatology: M33.20 Polymyositis M33.90 Dermatomyositis

Other _____

Other drugs used to treat the disease _____

Weight _____ kg/lbs Height _____ cm/in Date recorded _____

NKDA Known drug allergies _____

Concurrent meds _____

Adverse reactions with previous IG treatments? _____

If so, what brand of IVIG caused the reaction? _____

4 Prescribing Information

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

CHECK ONE

Medication	Dose	Directions
Asceniv™ 10% Gammaplex® 10% Bivigam® 10% Gamunex®-C 10% Gammagard® liquid 10% Octagam® 5% Gammagard® S/D 5% Octagam® 10% Gammagard® S/D 10% Panzyga® 10% Gammaked™ 10% Privigen® 10% Gammaplex® 5%	Infuse _____ grams OR _____ grams per kg OR _____ mg per kg intravenously every _____ weeks Divide total dose over _____ days (where clinically appropriate, round to the nearest vial size)	Rate protocol: Titrate initial and maintenance infusions per manufacturer's product labeling. Vascular access: Peripheral Central Port Infusion method: Gravity Pump

Other instructions _____

Premedication to be given 30 minutes prior to infusion: (please strike through if not required)

- Diphenhydramine 25mg by mouth for mild infusion reactions, may increase to 50mg for history of moderate to severe (contraindicated in patients with myasthenia gravis)
- Acetaminophen 650mg by mouth

Other _____

For patients weighing less than 60kg, the following weight-based dosing range will be used: Acetaminophen: 10–15mg/kg

For pediatric patients, the following weight- and age-based dosing range will be used:

- ≤9kg and/or <2 years old: Diphenhydramine 1mg/kg up to max of 6.25mg
- 2–5 years old and >9kg: Diphenhydramine 6.25mg to 12.5mg
- 6–12 years old: Diphenhydramine 12.5 to 25mg

Medications to be used as needed: (please strike through if not required)

- Diphenhydramine 25mg by mouth every 4–6 hours as needed for mild infusion reactions, may increase to 50mg for moderate to severe; maximum of 4 doses per day (contraindicated in patients with myasthenia gravis)
- Lidocaine 4% applied topically to insertion site prior to needle insertion as needed to prevent site pain
- Acetaminophen 650mg by mouth every 4–6 hours as needed for fever, headache or chills; maximum of 4 doses per day

Adverse reaction medications: (keep on hand at all times)

- Epinephrine 0.3mg auto-injector 2-pk for patients weighing greater than or equal to 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose
- Epinephrine 0.15mg auto-injector 2-pk for patients weighing less than 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose
- Diphenhydramine 25mg by mouth for mild allergic reactions and 50mg for moderate to severe

CHECK HERE

Hydration

Medication: 0.9% Normal Saline _____ mL infused over _____ minutes D5W _____ mL infused over _____ minutes

Timing: Pre-IG infusion _____ minutes before Post-IG infusion To be completed during the IVIG infusion

Flushing orders:

- 0.9% Normal Saline 3mL intravenous (peripheral line) or 10mL intravenous (central line) before and after infusion, or as needed for line patency
- Heparin 10 units per mL 3mL intravenous (peripheral line) as needed for final flush
- Heparin 100 units per mL 5mL intravenous (central line) as needed for final flush

Supplies: (please strike through if not required)

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

Quantity/Refills: Dispense 1 month supply. Refill x 1 year unless noted otherwise. Dispense 90 day supply. Refill x 1 year unless noted otherwise.

Other _____

Lab orders

Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy.

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

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

Date _____

Dispense as written

Date _____

Substitution allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. 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. © 2022 Accredo Health Group, Inc. I An Express Scripts Company. All rights reserved. IGL-00065-012122 CRP2101_007573.1

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.

Referral form ¹ (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
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

Medicare-approved PIDD diagnosis		
D80 – Immunodeficiency with predominantly antibody defects	D81.0 – Severe combined immunodeficiency (SCID) with reticular dysgenesis	D82.0 – Wiskott-Aldrich syndrome
D80.0 – Hereditary hypogammaglobulinemia	D81.1 – Severe combined immunodeficiency (SCID) with low T- and B-cell numbers	D82.1 – Di George’s syndrome
D80.2 – Selective deficiency of immunoglobulin A (IgA)	D81.2 – Severe combined immunodeficiency (SCID) with low or normal B-cell numbers	D82.4 – Hyperimmunoglobulin E (IgE) syndrome
D80.3 – Selective deficiency of immunoglobulin G (IgG) subclasses	D81.5 – Purine nucleoside phosphorylase (PNP) deficiency	D83 – Common variable immunodeficiency (CVID)
D80.4 – Selective deficiency of immunoglobulin M (IgM)	D81.6 – Major histocompatibility complex class I deficiency	D83.0 – CVID with predominant abnormalities of B-cell numbers and function
D80.5 – Immunodeficiency with increased immunoglobulin M (IgM)	D81.7 – Major histocompatibility complex class II deficiency	D83.1 – CVID with predominant immunoregulatory T-cell disorders
D80.6 – Antibody deficiency with near-normal immunoglobulins or with hyperimmunoglobulinemia	D81.89 – Other combined immunodeficiencies	D83.2 – CVID with autoantibodies to B- or T-cells
D80.7 – Transient hypogammaglobulinemia of infancy	D81.9 – Combined immunodeficiency, unspecified	D83.8 – Other CVIDs
D81 – Combined immunodeficiencies	D82 – Immunodeficiency associated with other major defects	D83.9 – CVID, unspecified
		G11.3 – Cerebellar ataxia with defective DNA repair

To receive in-home administration for intravenous immune globulin (IVIG) for the treatment of PIDD, Medicare Part B patients must be enrolled in the IVIG Demonstration initiative. For further information visit: <https://med.nordianmedicare.com/web/ivig>

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](https://www.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.

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
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: <input type="checkbox"/> Electrophysiological motor-sensory nerve conductions <input type="checkbox"/> Electromyography (EMG) <input type="checkbox"/> Cerebrospinal fluid (CSF) <input type="checkbox"/> Biopsy (muscle-nerve) - if necessary	

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

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

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

Fax completed form to 866.233.7151.

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