ameripharma SPECIALTY CARE

SUBCUTANEOUS IMMUNE GLOBULIN REFERRAL FORM

Phone#: 877-778-0318 Fax#: 877-778-0399

Patient information

Patient Name: _____ DOB: _____
Sex: ❑ Female ❑ Male SS #: _____
1˚ Language: _____ Wt:_____ ❑ kg ❑ lbs Ht:_____ ❑ cm ❑ in
Address: _____
Apt/Suite: _____ City:_____ State:_____ Zip:_____
Phone:_____ Alternate Phone:_____
Caregiver name: _____ Relation: _____
Local Pharmacy: _____ Phone: _____

Prescriber Information

Prescriber Name:_____
NPI #: _____
Address: _____
Apt/Suite: _____ City:_____ State:_____ Zip:_____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email address: _____
If shipping to prescriber: ❑ 1st Fill ❑ Always ❑ Never

Insurance Information (Please fax a copy of front and back of the insurance cards)

1˚ Insurance Plan: _____ Plan ID # _____ Policy Holder: _____ Relation: _____
2˚ Insurance Plan: _____ Plan ID # _____ Policy Holder: _____ Relation: _____

Clinical Information (Please fax all pertinent clinical and lab information)

ICD-10/Diagnosis Code: _____
Date of Diagnosis: _____
IgA deficiency: ❑ Yes ❑ No IgA level _____ mg/dL Date:_____
IgG trough:_____mg/dL Date:_____ Diabetic: ❑ Yes ❑ No
Required lab orders: CBC and CMP
Has patient received immune globulin previously? ❑ Yes ❑ No
If yes, previous product used: _____
Date of last infusion: _____ Date of next infusion: _____
Comorbidities: _____
Allergies: ❑ NKDA ❑ Other: _____

Prescription

Immune Globulin Products	❑ Hizentra® 20% *Weekly Sub-Q dose = IVIG Dose (g) x 1.37 / Number of weeks between IVIG doses* ❑ HyQvia® 10% ❑ GammaKed™ 10% ❑ Gammagard liquid® 10% ❑ Gamunex-C® 10% *Weekly Sub-Q dose = IVIG Dose (g) x 1.37 / Number of weeks between IVIG doses*
Therapy Regimen	Dose: _____ grams _____ times weekly Quantity/Refill: ❑ 1 month supply; refill x 12 months unless otherwise noted ❑ Other: _____ Administration rate and number of sites: ❑ Per manufacturer guidelines, as tolerated ❑ _____
Other Medications	Drug: _____ Strength: _____ Qty: _____ Directions: _____ Refills: _____ Drug: _____ Strength: _____ Qty: _____ Directions: _____ Refills: _____
Anaphylaxis Kit Orders	☒ Anaphylaxis Kit Order Administer per anaphylaxis protocol ☒ Diphenhydramine 25 mg capsule: Take 1-2 capsules as needed for mild reaction 1. Stop infusion 2. Call 911 and prescribing physician 3. Administer medications as per protocol ☒ Diphenhydramine Administer 25-50 mg slow IV/IM for moderate reaction Dispense: 2 x 50 mg vials ☒ Epinephrine ❑ Adult Administer 0.3 mg (1:1000) Sub-Q (≥ 30 Kg) ❑ Pediatric Administer 0.15 mg (1:2000) Sub-Q (< 30 Kg) Dispense: 2 pens ☒ Sodium Chloride 0.9% Use as directed per the protocol Dispense: 1 x 500 mL Bag
Ancillary Supplies	Pharmacy to dispense ancillary supplies in a quantity sufficient for proper administration and disposal of medication
Skilled Nursing Visits	To train patient/caregiver in Subcutaneous Immune Globulin administration, provide education related to disease state/therapy and assess general status. Typically 3 training visits required. Once trained and able to return demonstrate, patient/caregiver to self-adminster Subcutaneous Immune Globulin medication independently

Administration procedures to be followed per pharmacy protocol.

Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): _____

Prescriber's Signature:_____ Date: _____

I authorize Ameripharma Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.