allianceRx Walgreens + PRIME

Phone: 877-865-9035
Fax: 866-889-1667

Immunoglobulin Referral Form

☐ New to therapy ☐ Therapy Continuation

Deliver to: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site

Date Initiated: _____ Date Needed: _____

PATIENT INFORMATION

Full name _____

Date of birth _____ ☐ Male ☐ Female

Street address _____

City _____ State _____ Zip _____

Primary phone _____ Secondary phone _____

Patient's guardian _____ HIPPA Consent ☐ Yes ☐ No

Insurance company _____

Phone _____

Insured's name _____

Relationship to patient _____

ID _____ Group _____

Does patient have secondary insurance? ☐ Yes ☐ No

PRESCRIBER INFORMATION

Prescriber's name _____

State License _____

NPI _____ DEA # _____

Address _____

Phone _____

Fax _____

CLINICAL INFORMATION

Diagnosis code: _____

Weight: _____ Height: _____ Date recorded: _____

☐ NKDA ☐ Known drug allergies _____

Previous Immunoglobulin Therapies (if applicable):

_____

Please provide copy of primary and secondary insurance with this form

PRESCRIBING INFORMATION

No Brand Preference

☐ Immune Globulin Solution
☐ 5% ☐ 10% ☐ 20%
(No Brand Preference)

Brand Products

☐ Bivigam 10%
☐ Cuvitru 20%
☐ Flebogamma
☐ 5% ☐ 10%
☐ Gammagard Liquid 10%
☐ Gammagard S/D low IgA
☐ 5% ☐ 10%
☐ Gammaked 10%
☐ Gamunex-C 10%
☐ Hizentra 20%
☐ SDV ☐ PFS
☐ Hyqvia 10%
☐ Octagam
☐ 5% ☐ 10%
☐ Panzyga 10%
☐ Privigen 10%

Other

☐ _____
(Specify Product)

Route: ☐ IV ☐ SQ **Dose:** _____ **Qty:** _____ **Directions:** _____

IV access:
☐ Peripheral ☐ Port ☐ PICC

Flush Protocol:
Use 5mL to 10mL of 0.9% NaCl before and after each infusion. Sterile syringes required for PICC/PORT.
Maintain PICC with 3 to 5mL of 10unit/mL of heparin and maintain implanted port with 3 to 5mL of 100unit/mL of heparin.

Pre-medication:
☐ Acetaminophen 325mg tablets
Sig: Take two 325mg tablets (650mg) by mouth 30-60 minutes prior to infusion.
Qty: 2 per dose
☐ Diphenhydramine 25mg capsules
Sig: Take one to two 25mg capsules (25-50mg) by mouth 30-60 minutes prior to infusion.
Qty: 2 per dose

Medications to be used as needed:
☐ Lidocaine 2.5%/Prilocaine 2.5% Cream
Sig: Apply small amount to injection site 60 min prior to infusion
Qty: 1 tube
☐ Other Sig: _____ Qty: _____

Pre/Post Hydration:
_____ mL of ☐ 0.9% NaCl ☐ D5W ☐ before ☐ after ☐ concurrently at a rate of _____ mL/hour.
☐ Other: _____

Anaphylxis Kit:
☐ IVIG: Provide anaphylaxis kit per protocol (epinephrine 1 mg/mL ampule, diphenhydramine 50 mg/mL vial, diphenhydramine 12.5mg or 25mg tablets or capsules, 1000cc 0.9% NaCl, all infusion supplies)
☐ SQIG: Epinephrine Pen 2-pack (0.3 mg for ≥30 kg; 0.15 mg for <30 kg) Sig: Inject IM in event of anaphylaxis Qty: 1 pack Refills: PRN

Nursing Care:
☐ Infused in office or infusion center ☐ Home Nursing needed
☐ Nursing already coordinated:
Agency _____ Phone: _____
☐ RN to provide home nursing services for administration of IVIG or patient teach of SQIG, and as needed for IV site care and complications related to therapy.

Supplies: AllianceRx Walgreens Prime will provide all supplies, fluids and ancillary equipment necessary for home infusion.

Dispense (for all above): provide a 4-week supply or please specify if other: _____
Refills (all above): 1-year supply OR _____ (please specify)

Substitution Permissible. In order for a brand name product to be dispensed, the prescriber must handwrite "BRAND NECESSARY" or "BRAND MEDICALLY NECESSARY" in the space provided: _____

Prescriber's Signature (Dispense as Written) _____ **Date:** _____

Prescriber's Signature (Substitution Permissible) _____ **Date:** _____

For ARNP, NP, and PA, collaborative physician agreement is with: _____