IMMUNE GLOBULIN INTRAVENOUS ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 **FAX:** 800-530-8589 **WEB:** www.HealthDyneSpecialty.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

PATIENT INFORMATION

Patient: _____ Caregiver: _____

DOB: _____ ☐ Male ☐ Female Weight: _____ ☐ kgs or ☐ lbs (check one) Height: _____ ☐ in or ☐ cm (check one) Recorded Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Best Phone #:_____ ☐ Cell Alternate Phone #:_____ ☐ Cell Email:_____

Allergies: _____ Latex Allergy: ☐ Yes ☐ No

ICD-10 Code for requested therapy: _____ ICD-10 Code(s) for other medical conditions: _____

MEDICAL ASSESSMENT

PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION

PRIOR HISTORY:

1) Any adverse reaction with previous IG treatment? ☐ Yes ☐ No

2) If yes, what brand of IG caused a reaction? _____

3) Is this the Patient's first dose of THIS IG therapy? ☐ Yes ☐ No

PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

PRESCRIPTION INFORMATION

MEDICATION	DOSE	DIRECTIONS
☐ Bivigam 10% Solution ☐ Flebogamma DIF 5% Solution ☐ Flebogamma DIF 10% Solution ☐ Gammagard 10% Solution ☐ Gammagard 5% S/D Powder for injection ☐ Gammaked 10% Solution ☐ Gammaplex 5% Solution ☐ Gammaplex 10% solution ☐ Gamunex-C 10% Solution ☐ Octagam 5% Solution ☐ Octagam 10% Solution ☐ Panzyga 10% Solution ☐ Privigen 10% Solution for injection	Infuse _____ ☐ grams or ☐ mL OR Infuse _____ ☐ grams or ☐ mL per kg Starter Dose: _____	Infuse intravenously every _____ weeks Over _____ minutes/hours. **Infusion Rate:** Per MD recommendation _____ OR Per manufacturer guidelines _____ Method: _____

Quantity/Refills:

☐ Dispense 1 month supply. Refill 11x per year unless noted otherwise

Other: _____

Supporting medications (pre-med doses and as-needed doses)

☐ Diphenhydramine - 25 mg or 50 mg by mouth to be given 30 minutes prior to infusion and _____ as needed, maximum 4 doses per day. Quantity: _____ Refill: _____

☐ Acetaminophen - 325 mg or 500 mg by mouth to be given 30 minutes prior to infusion and _____ as needed, maximum 4 doses per day. Quantity: _____ Refill: _____

☐ Lidocaine 4% cream - apply topically as directed by physician

☐ Other: _____

Lab Orders: _____

Nursing Orders (if required): Teach? ☐ Yes ☐ No Administration at home? ☐ Yes ☐ No

Adverse Reaction Medication: (keep on hand at all times)

☐ EpiPen® 0.3 mg auto-injector 2 pk, dispense #1. Dispense 0.3 mg for patient weighing greater than or equal to 30 kg. Administer prn severe anaphylactic reacton times one dose: may repeat one time.

☐ EpiPen Jr.® 0.15 mg auto-injector 2 pk, dispense #1. Dispense 0.15 mg for patient weighing less than 30 kg. Administer prn severe anaphylactic reacton times one dose: may repeat one time.

☐ Diphenhydramine 25 mg - 50 mg administered by mouth prn allergic reaction/anaphylaxis. Directions: _____

Other: _____

SUPPLIES

VENOUS ACTION	FLUSHES	HYDRATION
☐ Peripheral ☐ Midline ☐ Central Non-Port ☐ Central Port ☐ PICC ☐ Other:	Sodium Chloride 0.9% (sterile field) flush: ☐ 3 mL ☐ 5 mL ☐ 10 mL ☐ Flush IV access Directions: _____ Heparin 10 units/mL for **Peripheral IV:** ☐ 3 mL ☐ 5 mL Heparin 100 units/mL for **Central IV:** ☐ 3 mL ☐ 5 mL To maintain line, flush with Heparin _____	☐ Normal Saline 0.9% ☐ D5W ☐ Infuse _____ mLs over _____ minutes ☐ prior to, and ☐ after Directions: _____

Dispense all supplies needed for infusion therapy and line maintenance. Dispense one month supply. Refill 11x per year or as needed unless noted otherwise.

Signature: _____

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Patient: _____ DOB: _____

INJECTION TRAINING:	OFFICE TO COORDINATE	HEALTHDYNE SPECIALTY TO COORDINATE

PRESCRIBER INFORMATION

Anticipated Start Date: _____ Prescriber Specialty: _____

Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other: _____

Fax #: _____ Contact Name: _____

Office Address: _____ City: _____ State: _____ Zip: _____

The terms and conditions posted at www.HealthDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference. The data privacy terms posted at www.HealthDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.

☐ I understand that HealthDyne Specialty may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.

Prescriber's Name: _____ Prescriber's Signature: _____ Date: _____

☐ Use substitution ☐ Dispense as written