# Subcutaneous Immune Globulin

31 Moody Rd. Enfield, CT 06082
1111 Elm St. Ste 12 West
Springfield, MA 01089
Phone & Fax: 844-469-5933

## Patient Information

Patient Name: ______________________ DOB: __________
Sex: ❑ Female ❑ Male SSN: __________
Language: __________ Wt: ______ ❑ kg ❑ lbs Ht: ______ ❑ cm ❑ in
Address: __________
Apt/Suite: ______ City: __________ State: ______ Zip: ______
Phone: __________ Alternate Phone: __________
Caregiver name: __________ Relation: __________
Local Pharmacy: __________ Phone: __________

## Prescriber + Shipping Information

Prescriber Name: __________
NPI: __________
Address: __________
Apt/Suite: ______ City: __________ State: ______ Zip: ______
Contact: __________
Phone: __________ Alternate: __________
Fax: __________
Email address: __________
If shipping to prescriber: ❑ First 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: __________

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

**Diagnosis Code(s):** __________
Date of Diagnosis: __________
IgA deficiency: ❒yes ❒No IgA level ______ mg/dl Date: __________
IgG trough: ______ mg/dL Date: ______ Diabetic: ❒Yes ❒No

Has patient received immune globulin previously? ❑ Yes ❑ No
If yes, product information: __________
Date of last infusion: __________ Date of next infusion: __________

Comorbidities: __________
Concomitant Medications: __________
Allergies: ❒NKDA ❒Other: __________

## Prescription

| Prescription | Drug | Dose and Directions | Quantity | Refills |
|---|---|---|---|---|
| Immune Globulin Products | ❒Cuvitru 20%<br>❒Cutaquig 16.5% | __________<br>Number of sites: ______ Rate: ❒Per manufacture guidelines, as tolerated ❒ ______<br>*Weekly SC dose = IVIG Dose (g) x 1.3 / IVIG weekly interval originally given* | ______ | ______ |
| | ❒Hizentra® 20% | __________<br>Number of sites: ______ Rate: ❒Per manufacture guidelines, as tolerated ❒ ______<br>*Weekly SC dose = IVIG Dose (g) x 1.37 / IVIG weekly interval originally given* | ______ | ______ |
| | ❒Gammaked™ 10%<br>❒Gammagard liquid® 10%<br>❒Gamunex-C® | __________<br>__________<br>__________<br>Number of sites: ______ Rate: ❒Per manufacture guidelines, as tolerated ______<br>*Weekly SC dose = IVIG Dose (g) x 1.37 / IVIG weekly interval originally given* | ______<br>______<br>______ | ______<br>______<br>______ |
| | ❒HyQvia® 10% | Please complete and attach HyQvia Prescription Referral form which can be located at: http://www.hyqviahcp.com | | |
| Other Medications | Acetaminophen ______ mg | ❒ Premedication 30 minutes prior to infusion. ❒Post infusion every 4-6 hours as needed for fever/ headache. | | |
| | Diphenhydramine ______ mg | ❒Premedication 30 minutes prior to infusion. ❒Post infusion every 4-6 hours as needed for itching/ site reactions. | | |
| | ❒Lidocaine 2.5% and Prilocaine 2.5% Cream 30 grams. Apply small amount topically to insertion site(s) prior to needle insertion as needed. | | | |
| | Drug: ______ Strength: ______ Quantity to dispense: ______<br>Directions: __________ Refills: ______ | | | |

***The quantity and refills for pre-treatment and flushing protocol medications will match the primary therapy administration requirements.***

| | | | | |
|---|---|---|---|---|
| Anaphylaxis Order and Medication | Orders: 1. Stop infusion | 2. Call 911 and prescribing physician 3. Administer medications below as per protocol | | |
| | Epinephrine Auto-injector | ❒Administer 0.15 mg (15 - 30 kg) IM or subcut as needed<br>❒Administer 0.3 mg (≥ 30 kg) IM or subcut as needed | Quantity: 2 | Refills: ______ |
| Supplies & Equipment | ☑Syringe driver/pump(s) and supplies provided as needed for administration and appropriate disposal of infusion materials. | | | |
| Skilled Nursing Visits | ☑To train patient/caregiver in Subcutaneous Immune Globulin administration, provide education related to disease state/ therapy and assess general status. Typically 2-4 training visits required. Once trained and able to return demonstrate, patient/ caregiver to self-administer Subcutaneous Immune Globulin medication independently unless otherwise specified. | | | |

Prescriber's Signature: ______________________ Date: __________

I authorize Mylyfe Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Mylyfe Pharmacy.

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