HPC SPECIALTY PHARMACY

Immune Globulin Autoimmune Disorder Referral Form***Seperate RX Needed

Sales/Advocate _____

PATIENT INFORMATION

Patient Name: _____
Date of Birth: ____ /____ / ____ ☐ Male ☐ Female
Physical Address: _____
City: _____ State: _____ Zip: _____
Home: (____) - ____ - _____

Mobile: (____) - ____ - _____ Emerg. Contact: _____
Email: _____ Emerg. Phone: (____) - ____ - _____
Preferred method of contact: ☐ Home ☐ Email ☐ Mobile ☐ Text
Height: _____ in Weight: _____ lb Date: ____ /____ / ____
Allergies: _____ Social Security: _____

PRESCRIPTION BENEFITS INFORMATION *(Please attach front and back of insurance card)*

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____
Clinic/Hospital Affiliation: _____

Phone: (____) - ____ - _____
Fax: (____) - ____ - _____
NPI #: _____

Medications if needed please attach a seperate list

1. _____
2. _____
3. _____
4. _____
5. _____

CLINICAL INFORMATION - PRIMARY DIAGNOSIS - ICD-10

☐ Infective Polyneuritis (Guillain-Barre Syndrome)
☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
☐ Dermatomyositis
☐ Inflammatory Polyneuropathy, Unspecified
☐ Multiple Sclerosis (MS)
☐ Multifocal Neuropathy (MMN)
☐ Myasthenia Gravis with (Acute) Exacerbation
☐ Myasthenia Gravis without (Acute) Exacerbation
☐ Pemphigoid
☐ Polymyositis
☐ Stiff-Person Syndrome
☐ Other: _____

ICD-10: _____

NORMAL LABS AND CLINICALS NEEDED FOR PA

1. Diagnostic testing results (one or all) to match diagnosis:
   Electromyography (EMG)
   - Nerve Biopsy
   - Muscle Biopsy
   - Nerve Conduction Study
2. Recent BUN and Creatinine Results
3. H&P including: supporting documentation of diagnosis, previously failed treatments(s)
4. Medication Lists

Please note this is not a prescription. Please fax or Escribe a prescription over with the information listed below**

Administer: ☐ SCIG ☐ IVIG **Medication** ☐ Octagam ☐ Privigen ☐ Gammagard S/D ☐ Gammunex-C ☐ Hizentra ☐ Gammaplex ☐ Other

Dose: *(please select option(s) and provide complete information)*
☐ **Loading Dose:** _____ gm/kg OVER _____day(s), then ☐ **Maintenance Dose:** _____ gm/kg OVER _____day(s), EVERY _____ week(s) x_____ Refills
☐ **Other Regimen:** _____

Infusion Rate:
☐ Start at _____ mL/hr, then increase by _____ mL/hr every _____ minutes to maximum rate _____ mL/hr

Access: ☐ Peripheral ☐ PICC ☐ Port ☐ Other: _____

IV Maintenance (Flushing): ☐ Dispense Quantity Sufficient

· Sodium Chloride 0.9% 10mL Prefilled Syringe: Flush IV access device with sodium chloride 3-10mL to maintain line patency.
· Heparin 10 units/mL 5mL Prefilled Syringe: Flush peripheral IV access device with Heparin 10 units/mL 1-5mL as needed to maintain line patency. **(pt<10kg)**
· Heparin 100 units/mL 5mL Prefilled Syringe: Flush peripheral IV access device with Heparin 100 units/mL 3-5mL as needed to maintain line patency. **(pt>10kg)**

Pre-Treatment: ☐ Dispense Quantity Sufficient
Acetaminophen 325mg Tablet: 1-2 tablets by mouth 15-30 minutes before each infusion.
Diphenhydramine 25mg Capsule: 1-2 capsules by mouth 15-30 minutes before each infusion.

☐ **Adverse/Anaphyl Reactions:** Anaphylaxis kit to be used in the event of anaphylatic reaction per HPC Protocol and will contain the following:

· Diphenhydramine 25mg Capsule #4 · Diphenhydramine 50mg/mL 1mL vial #2 · Sodium Chloride 0.9% 500mL Bag #1
· Epinephrine Injection Auto-Injector 0.3mg (>30kg pt) or 0.15mg (<30kg pt) Two-Pack #1 · Sodium Chloride 0.9% 10mL Prefilled Syringe #4

PRESCRIBER SIGNATURE-PLEASE SIGN BELOW TO AUTHORIZE SUPPLIES AND NURSING ORDERS

☐ **Ancillary Supplies:** Dispense ancillary supplies and equipment *(including pump and pole)* needed to provide home infusion therapy.

☐ **Nursing Orders for Home Infusion (IV Only)** Frequency of vital signs monitoring:
If initial infusion or more than 8 weeks since last infusion: Prior to infusion,q 15 minutes for the first hour,q 30 minutes during the second hour,q 1 hour for the remainder of the infusion. If subsequent infusion within 8 weeks: Prior to infusion,q 15 minutes for the first hour, q 1 hour for the remainder of the infusion

SCIG TEACHING NEEDS ☐ Patient independent ☐ Patient teaching needed

_____ _____
Signature **Date**

Note:Please fax or Escribe a RX for the medication. Signing here authorizes supplies and nursing only.

PHONE: 1-800-757-9192
www.HPCSpecialtyPharmacy.com

PLEASE INCLUDE ALL MEDICAL RECORDS & LAB VALUES
PLEASE FAX TO 1-855-813-0583