Immune Globulin Primary Immune Deficiency Referral Form***Seperate RX Needed

HPC SPECIALTY PHARMACY
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

Please select diagnosis from the drop down window below
if the diagnosis is not listed please select other and indicate diagnosis in the other diagnosis box below

Diagnosis Code Common Variable Immunodeficiency **ICD-10** _____

Other Diagnosis _____ **ICD-10** _____

NORMAL LABS AND CLINICALS NEEDED FOR PA

1. Labs:
- **Ig Serum Levels: IgG, IgA, and IgM**
- **Subclass Levels: Ig1, Ig2, Ig3, Ig4**
- **Immunization challenge test results**
- **Titer values**
- **Recent BUN and Creatinine Results**

2.Diagnostic testing 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