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: ____________________

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. Drug names are the property of their respective owners.

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