USspecialty
powered by WellDyne

IMMUNE GLOBULIN SUBCUTANEOUS ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 **FAX:** 800-530-8589 **WEB:** www.usspecialtycare.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 AND 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
☐ Gammagard 10% Liquid ☐ Gammagard 10% Solution ☐ Gamunex- C 10% Solution ☐ Hizentra 20% Solution Limited Distribution ☐ Cuvitru 20% Solution ☐ Hyqvia 10% Solution ☐ Other: ______________ Quantity/Refills: ☐ Dispense 1 month supply. Refill 1x per year unless noted otherwise ☐ Other: ______________	Infuse ______ ☐ grams or ☐ mL OR Infuse ______ ☐ grams or ☐ mL per kilogram Starter Dose: ______________	Subcutaneously every_________ weeks into _________ sites over _________ minutes/hours. Infusion Rate: Per MD recommendation __________ OR Per manufacturer guidelines ________ Method: ______________

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: Dispense all supplies as needed for infusion therapy ______________________ (signature)

INJECTION TRAINING: ☐ **OFFICE TO COORDINATE** ☐ **USSC TO COORDINATE**

PRESCRIBER INFORMATION

Anticipated Start Date: ______________________ Prescriber Specialty: ______________________

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

Fax #: ______________________ Contact Name: ______________________

Office Address: ______________________ City: ______________________ State: ______ Zip: _________

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The data privacy terms posted at www.usspecialtycare.com have been read by the person signing this form and are incorporated into this document by reference.
☐ I understand that USSC 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

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