

Date: _____

Patient information

Patient name: _____

Patient address: _____

Patient phone number: _____

Member ID: _____

Patient date of birth: _____

Allergies: No known allergies _____

Weight: _____ lbs kg

Primary diagnosis:

- Hereditary hypogammaglobulinemia, D80.0
- Immunodeficiency with increased IgM, D80.5
- Common variable immunodeficiency, D83.8
- Mixed hyperlipidemia, E78.2
- Wiskott-Aldrich syndrome, D82.0
- Chronic inflammatory demyelinating polyneuropathy, G61.81
- Multiple sclerosis, G35
- Myasthenia gravis, G70.01
- Lupus, L93.0
- Dermatomyositis, M33.90
- Immune thrombocytopenic purpura, D69.3

Clinical documents (please attach):

History and physical (H and P) and progress notes within past six months

Note: H and P will include documented infection history and treatment.

Venous access: Peripheral Port PICC SQ

Other: _____

Gravity as tolerated by patient Pump: _____

Has prescriber initiated prior authorization? Yes No

First dose? Yes No

Expected date of first/next infusion: _____

Site of care: Patient's home Physician's office

Outpatient infusion clinic: _____

Prescriber signature: _____

Prescriber name: _____

Prescriber address: _____

DEA number: _____

NPI number: _____

Prescriber phone number: _____

Prescriber fax number: _____

Please provide supervising prescriber information (if applicable):

Prescriber name: _____

Prescriber address: _____

Prescriber phone number: _____

DEA number: _____

NPI number: _____

Note: If you leave a field blank, we will not process this patient request. We will contact your office for clarification.

You can send this prescription electronically by selecting "CenterWell Specialty Pharmacy" (National Council for Prescription Drug Programs [NCPDP] ID number 3677955) from the list of pharmacies on your e-prescribing tool.

Prescription information

- Alyglo® Asceniv™ 10% Cutaquig® Cuvitru®
- Flebogamma® 5% Flebogamma 10% Gammagard Liquid® 10%
- Gammagard S/D 5% Gammagard S/D 10% Gammaked™
- Gammaplex® 10% Gamastan® Gamunex®-C Hizentra® PFS
- HyQvia® Octagam® 5% Octagam 10% Panzyga® Privigen®
- Xembify®

We may round to the nearest gram vial size.

Directions: _____

Divide dose over _____ days.

Infuse per manufacturer guidelines or _____

Quantity: 28-day supply Refill for one year or _____

Pharmacy to dispense ancillary supplies as needed to establish IV and administer drug, including coordination of home health nursing unless otherwise noted. Please strike-through items that are not required:

Normal saline 10 mL IV flush syringe

Directions: Use as directed to flush line with 10 mL before and after infusion and P.R.N. line care.

heparin 100 unit/mL 5 mL prefilled syringe (central line patients)

Directions: Use as directed to flush line with 5 mL after final saline flush.

heparin 10 unit/mL 5 mL prefilled syringe (for hep-lock)

Directions: Use as directed to flush line with 5 mL for hep-lock.

Premedications (Please strike-through items that are not required.):

diphenhydramine 25 mg capsules **Quantity:** 10 **Refill** for one year or _____

Directions: Take one to two capsules PO 30–60 minutes prior to infusion and every four to six hours P.R.N. The maximum is four doses per day.

acetaminophen 325 mg tablets **Quantity:** 10 **Refill** for one year or _____

Directions: Take one to two tablets PO 30–60 minutes prior to infusion and every four to six hours P.R.N. The maximum is four doses per day.

Other premedications: _____

lidocaine/prilocaine cream 2.5%-2.5%

Directions: Apply topically to needle insertion site 30–60 minutes prior to needle insertion as directed. **Quantity:** 30 grams **Refill** for one year or _____

Hydration orders:

dextrose 5% **Quantity:** 250 mL 500 mL Other: _____

Directions: _____

sodium chloride 0.9% **Quantity:** 250 mL 500 mL Other: _____

Directions: _____

Anaphylaxis kit maintained in the patient's home:

diphenhydramine 50 mg/mL injection **Quantity:** One vial **Refills:** 0

Directions: Use as directed via slow IV push as needed for anaphylaxis.

diphenhydramine 25 mg capsules **Quantity:** 10 capsules **Refills:** 0

Directions: Take 25–50 mg PO as needed for anaphylaxis.

epinephrine 0.3 mg or epinephrine 0.15 mg (for patients weighing 15–30 kg)

Directions: Use as directed IM as needed for anaphylaxis.

Quantity: Two-pack **Refills:** 0

Skilled home infusion nursing visit to establish venous access, provide patient education related to therapy and disease state, administer medication as prescribed, and assess general status and response to therapy. The visit frequency is based on prescribed dosage orders.