CenterWell Specialty Pharmacy

E-prescribe: NCPDP ID number 3677955
Fax: 800-345-8534
Phone: 855-264-0104
Monday – Friday, 8 a.m. – 11 p.m., and
Saturday, 8 a.m. – 6:30 p.m., Eastern time

Immune Globulin Prescription Request

Date: _____

Patient information

Patient name: _____
Patient address: _____
Patient City:_____State:_____ZIP code: _____
Patient phone number: _____
Member ID: _____
Patient date of birth: _____
Allergies: ❑ No known allergies _____
Weight: _____❑ lbs ❑ kg

Primary diagnosis:

❑ Congenital 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 to include documented infection history/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

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