Immune Globulins (Ig) Enrollment Form

CVS specialty™ **Fax Referral To:** 1-877-232-5455
Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813
Phone: 1-800-896-1464

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ Address: _____ City, State, ZIP: _____
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____ DOB: _____ Gender: ☐ Male ☐ Female
Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP: _____
Phone: _____ Fax _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

Insurance Company: _____ ID#: _____

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Service Location:

☐ Home or Coram AIC Diluents, Flushes, Supplies, Nursing Services for drug administration/therapy teach train
☐ MD Office/Other Drug Only for facility administration

Diagnosis (ICD-10):

☐ C91.10 Chronic lymphocytic leukemia of B-cell type not having achieved remission
☐ D69.3 Immune thrombocytopenic purpura
☐ D80.0 Congenital Hypogammaglobulinemia
☐ D80.2 Selective deficiency of IgA
☐ D80.3 Selective deficiency of IgG subclasses
☐ D80.4 Selective deficiency of IgM
☐ D80.5 Immunodeficiency with increased IgM
☐ D80.6 Antibody deficiency with near-normal Immunoglobulins or with hyperimmunoglobulinemia
☐ D80.7 Transient hypogammaglobulinemia
☐ D81.0 SCID with reticular dysgenesis
☐ D81.2 SCID with low or normal B cell numbers
☐ D81.5 Purine nucleoside phosphorylase deficiency
☐ D81.6 Major histocompatibility complex class I
☐ D81.7 Major histocompatibility complex class II
☐ D81.89 Other combined immunodeficiencies
☐ D81.9 SCID (Unspecified)
☐ D82.0 Wiskott-Aldrich syndrome
☐ D82.1 De George's syndrome
☐ D82.4 Hyperimmunoglobuin E syndrome
☐ D83.0 Common Variable Immunodeficiency with Predominant abnormalities of B cell numbers and function
☐ D83.1 Common Variable Immunodeficiency with predominant Immunoregulatory T cell disorders
☐ D83.2 Common Variable Immunodeficiency with autoantibodies to B or T cells
☐ D83.9 Common Variable Immunodeficiency, unspecified
☐ G11.3 Cerebellar ataxia with defective DNA
☐ G35 MS (Relapsing Remitting)
☐ G61.0 GBS
☐ G61.81 CIDP
☐ G61.89 MMN
☐ G70.00 MG without acute exacerbation
☐ G70.01 MG with acute exacerbation
☐ M33.20 Polymyositis
☐ M33.90 Dermatomyositis
☐ Other Code: _____ Description: _____

For additional ICD-10 information, please visit CVS Specialty Healthcare Professionals Website
https://www.cvsspecialty.com/wps/portal/specialty/healthcare-professionals/about-us

Patient Clinical Information:

Allergies/rxn: _____ Height: _____in/cm Weight: _____lb/kg
History of: ☐ Headache ☐ Diabetes ☐ CHF ☐ Renal issues
First time receiving Immune Globulin? ☐ Yes ☐ No If first dose, please provide IgA level: _____
If No, previous product used: _____ Last dose given: _____ Next dose due: _____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Immune Globulins (Ig) Enrollment Form

Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION **Select One Immune Globulin Product:**

☐ Asceniv 10%
☐ Bivigam 10%
☐ Cuvitru 20% (SC route)
☐ Gamastan (IM route)
☐ Gammagard Liq 10%
☐ Gammagard S/D ☐ 5% ☐ 10%
☐ Gammaked 10%
☐ Gammaplex ☐ 5% ☐ 10%
☐ Gamunex-C 10%
☐ Hizentra 20% PFS (SC route)
☐ Hizentra 20% vials (SC route)
☐ HyQvia 10% (SC route)
☐ Octagam ☐ 5% ☐ 10%
☐ Panzyga 10%
☐ Privigen 10%
☐ Xembify 20% (SC route)
☐ Other: _____

Route: ☐ SC ☐ IV **Dose:** ☐ ____ grams ☐ ____ mg/kg (dose will be rounded to the nearest vial size)

Directions: ☐ Daily x _____ Day (s), every _____Week ☐ Infuse at _____ mL/hr or infuse over _____ hours

☐ Follow FDA package insert infusion rate directions ☐ Other: _____

Nursing: ☐ Please arrange nursing for administration ☐ Patient may be taught to self-infuse

☐ OK to administer first dose in the home if pharmacy deems appropriate

Lab Orders: _____

****ITEMS BELOW THIS LINE WILL ONLY BE SENT FOR INFUSIONS DONE AT HOME/CORAM AIS****

MEDICATION	ROUTE	DOSE /STRENGTH	DIRECTIONS
Catheter: ☐ PIV ☐ PORT ☐ PICC	IV	NA	Catheter Care/Flush – Only on IG drug admin days – SASH or PRN to maintain IV access and patency • PIV – NS 5mL (Heparin 10 units/mL 3-5mL if multiple days) • PORT/PICC – NS 10mL & Heparin 100units/mL 3-5mL, and/or 10mL sterile saline to access port a cath
Hydration: ☐ NS ☐ D5W	IV	Pre: ☐ 500mL ☐ 1000mL ☐ Other:_____ Concurrent: ☐ 500mL ☐ 1000mL ☐ Other:___ (Not to be infused using the same access as Ig) Post: ☐ 500mL ☐ 1000mL ☐ Other:_____	Hydration max infusion rate _____ mL/hr (Adult max rate 250mL/hr unless otherwise indicated)
☐ Diphenhydramine ** For rash or hives (If oral, patient may be instructed to purchase from retail)	☐ PO ☐ IV ☐ IM	☐ 25mg-50mg ☐ Peds: 1mg/kg ☐ Other: _____	☐ PRN mild/moderate allergic reaction ☐ Premed 30 minutes prior to infusion ☐ Initial dose (IV only): Administer 25 mg x 1 dose; may repeat in 3-5 minutes if needed ☐ Subsequent doses: may repeat every 4-6 hours as needed (Adult max 100mg/day) ☐ Other: _____
☐ Acetaminophen ** For aches, pain or fever (patient may purchase from retail)	PO	☐ 325mg-650mg ☐ Other: _____	☐ Premed 30 minutes prior to infusion ☐ May repeat every 4-6 hours as needed (Adult max 2000mg/day) ☐ Other: _____
☐ Lido/Prilocaine 2.5%/2.5% ☐ Lidocaine 4%	TOP	30-60 grams	Apply to injection sites at least 1 hour before access Cover with occlusive dressing
Epinephrine **home nursing requirement**	☐ IM	☐ Adult 1:1000, 0.3mL (>30kg/>66lbs) ☐ Peds 1:2000, 0.3mL (15-30kg/33-66lbs) ☐ Infant 0.1mL/0.1mL, 0.1mL (7.5-15kg/16.5-33lbs)	PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed
Additional Medication: _____ _____	_____ _____	_____ _____	_____ _____

Quantity: ☐ 1 cycle ☐ 1 month ☐ 3 months ☐ Other: _____ Refills: ☐ 1 year ☐ _____

RX includes related diluents, pumps, DME, ancillary supplies as necessary for drug administration/catheter maintenance.

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

X_____ X_____

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