Immunoglobulins (Ig) Enrollment Form

CVS specialty®

Fax Referral To: 1-866-843-3221 **Phone:** 1-866-899-1661
Email Referral To: DL-NCCNewReferral@cvshealth.com

Coram® CVS specialty® infusion services

Six Simple Steps to Submitting a Referral

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

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female
Address: _____City, State, ZIP Code: _____
Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below)
Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____
Parent/Caregiver/Legal Guardian Name (Last, First): _____**Relationship to patient**: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP Code: _____
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: _____
Diagnosis (ICD-10):
ICD-10 Code: _____ Description: _____
Patient Clinical Information:
Allergies/rxn: _____ Height: _____in/cm Weight: _____lb/kg
History of: ☐ Headache ☐ Diabetes ☐ CHF ☐ Renal issues
First time receiving Immunoglobulin? ☐ Yes ☐ No If first dose, please provide IgA level: _____
If No, previous product used: _____ Last dose given: _____ Next dose due: _____

5 PRESCRIPTION INFORMATION **Select One Immunoglobulin Product:**

☐ Asceniv 10%
☐ Bivigam 10%
☐ Cutaquig 16.5% (SC route)
☐ Cuvitru 20% (SC route)
☐ Gamastan (IM route)
☐ Gammagard Liq 10%
☐ Gammagard S/D ☐ 5% ☐ 10%
☐ Gammaked 10%
☐ Gammaplex ☐ 5% ☐ 10%
☐ Other: _____
☐ 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)

Route: ☐ SC ☐ IV **Dose:** ☐ _____ grams ☐ _____ mg/kg (dose will be rounded to the nearest vial size)
Directions: ☐ Daily x _____ Day (s), every _____Week ☐ Other: _____
☐ Follow FDA package insert infusion rate directions ☐ Infuse at max rate of ____ mL/hr
Nursing: Specialty pharmacy to coordinate home health infusion nurse visit as necessary? ☐ Yes ☐ No
Site of Care: ☐ Home Infusion* ☐ Coram Ambulatory Infusion Suite (AIS) * ☐ Prescriber's Office ** ☐ Other Infusion Clinic
*Home Infusion/Coram AIS: Diluents, Flushes, Supplies, Nursing Services, or drug administration/therapy teach train.
**Prescriber's Office/Other Infusion Clinic:
Drug only for facility administration: ☐ OK to administer first dose in the home if pharmacy deems appropriate ☐ Patient may be taught to self-infuse (SC)
Lab Orders: (Only if IV and Site of Care is Home/AIS): _____

Proceed to next page to complete form

Scan code or visit cvs.co/ig-comparison

Immunoglobulins (Ig) Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Prescriber Name: _____ Prescriber Phone: _____

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

MEDICATION	ROUTE	DOSE /STRENGTH	DIRECTIONS
Catheter ☐ PIV ☐ PORT ☐ CVC/PICC	IV	N/A	Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access and patency PIV: NS 5 mL (Heparin 10 units/ml 3-5 mL if multiple days) CVC/PICC: NS 10 mL & Heparin 10 units/mL or 100 units/mL 3-5 mL PORT: 10 mL sterile saline to access PORT w/ huber needle NS 10 mL & Heparin 100 units/mL 3-5 mL
Hydration: ☐ NS ☐ D5W ☐ Other	IV	Pre: ☐ 500 mL ☐ 1000 mL ☐ Other: _____ Concurrent: ☐ 500 mL ☐ 1000 mL ☐ Other: _____ (Not to be infused using the same access as Ig) Post: ☐ 500 mL ☐ 1000 mL ☐ Other: _____	Hydration max infusion rate _____ mL/hr (Adult max rate 250 mL/hr unless otherwise indicated)
☐ Diphenhydramine *(patient may be instructed to purchase from retail)*	☐ PO ☐ IV	☐ 25 mg-50 mg ☐ Peds: 1 mg/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 for rash or hives (Adult max 100 mg/day) ☐ Other: _____
☐ Acetaminophen *(patient may be instructed to purchase from retail)*	PO	☐ 325 mg-650 mg ☐ Peds: 10-15 mg/kg ☐ Other: _____	☐ Premed 30 minutes prior to infusion ☐ May repeat every 4-6 hours as needed for aches, pain, or fever (Adult max 2000 mg/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 ***nursing requires***	☐ IM ☐ SC	☐ 1:1000, 0.3 mg/ 0.3 mL (greater than 30 kg/66lbs) ☐ 1:2000, 0.15 mg/0.3 mL (15-30 kg/33-66lbs) ☐ 1:1000, 0.01 mg/kg, Max 0.3 mg (under 15 kg)	Mild-Moderate Reactions. May repeat in 3-5 minutes as needed For severe allergic reaction also call 911
☐ Additional Medication: _____ _____ _____	Other: _____ _____ _____	Other: _____ Other: _____ Other: _____	Other: _____ Other: _____ Other: _____

Notes: _____

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

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 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Prescriber's Signature: _____Date: _____**	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature: _____Date: _____**

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

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 above, I hereby CVS Specialty® 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.