IMMUNE GLOBULIN SUBCUTANEOUS ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 **FAX:** 800-530-8589 **WEB:** www.WellDyneSpecialty.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 & 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% Solution ☐ Gammaked 10% Solution ☐ Gamunex-C 10% Solution ☐ Hizentra 20% Solution or PFS ☐ Xembify 20% **Limited Distribution** ☐ Cutaquig 16.5% Solution ☐ Cuvitru 20% Solution ☐ Hyqvia 10% Solution ☐ Other: _____ **Quantity/Refills:** ☐ Dispense 1 month supply. Refill 11x per year unless noted otherwise ☐ Other: _____	Infuse _____ ☐ grams or ☐ mL OR Infuse _____ ☐ grams or ☐ mL per kg 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: _____

Dispense 1 month supply. Refill 11x per year unless noted otherwise. Signature: _____

PRESCRIBER INFORMATION

INJECTION TRAINING: OFFICE TO COORDINATE WELLDYNE SPECIALTY TO COORDINATE

Anticipated Start Date: _____ Prescriber Specialty: _____

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

Fax #: _____ Contact Name: _____

Office Address: _____ City: _____ State: _____ Zip: _____

The terms and conditions posted at www.WellDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.

The data privacy terms posted at www.WellDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.

☐ I understand that WellDyne Specialty 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