

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.

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	Patient:Caregiver:		
PATIENT INFORMATION	DOB: Male Female Weight: kgs or		
	Address:		
	Best Phone #: Cell Alternate Phone	#: Cell Ema	ail:
	Allergies:		Latex Allergy: Yes No
	ICD-10 Code for requested therapy: ICD-10 Code(s) for other medical conditions:		
	PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION		
MEDICAL ASSESSMENT	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		
	MEDICATION	DOSE	DIRECTIONS
	Gammagard 10% Solution		Cub autonomiali autonomia
	Gammaked 10% Solution		Subcutaneously every weeks into sites
TION	Gamunex-C 10% Solution		over minutes/hours.
	Hizentra 20% Solution or PFS	Infuse grams or mL	
	Xembify 20% Limited Distribution	OR	Infusion Rate:
	Cutaguig 16.5% Solution	Infuse grams or mL per kg	Per MD recommendation
	Cuvitru 20% Solution		OR
	Hyqvia 10% Solution	Starter Dose:	Per manufacturer guidelines
	Other:	Starter bose.	Method:
	Quantity/Refills:		
RMA	Dispense 1 month supply. Refill 11x per year unless noted otherwise Other:		
PRESCRIPTION INFORMATION	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:		
SCR	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:		
PRE:	Lidocaine 4% cream - apply topically as directed by physician		
	Other:		
	Lab Orders: Number Orders (if required): Tageh? Vac. No. Administration at home? Vac. No.		
	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. Significant Significa	gnature:	
INJECTION TRAINING: OFFICE TO COORDINATE WELLDYNE SPECIALTY TO COORDINATE			
RESCRIBERINFORMATION	Anticipated Start Date: Prescriber Specialty:		
	Ship to: Patient Physician Clinic Other:		
	Fax #: Contact Name: _		
	Office Address:		
S S	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.		
RIBE	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.		
SCF	I understand that WellDyne Specialty may transfer this prescription to	. , , , , , , , , , , , , , , , , , , ,	'
Ж	Prescriber's Name: Pres	scriber's Signature:	Date:

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Use substitution

Dispense as written