IMMUNE GLOBULIN INTRAVENOUS 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
Bivigam 10% Solution Flebogamma DIF 5% Solution Flebogamma DIF 10% Solution Gammagard 10% Solution Gammagard 5% S/D Powder for injection Gammaked 10% Solution Gammaplex 5% Solution Gammaplex 10% solution Gamunex-C 10% Solution Octagam 5% Solution Octagam 10% Solution Panzyga 10% Solution Privigen 10% Solution for injection	Infuse _________ grams or mL OR Infuse _________ grams or mL per kg Starter Dose: ______________	Infuse intravenously every _________ weeks Over _________ minutes/hours. **Infusion Rate:** Per MD recommendation _________ OR Per manufacturer guidelines _________ Method: ______________ ______________ ______________

Quantity/Refills:

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

Other: ______________________

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: ______________________

SUPPLIES

VENOUS ACTION	FLUSHES	HYDRATION
Peripheral Midline Central Non-Port Central Port PICC Other:	Sodium Chloride 0.9% (sterile field) flush: 3 mL 5 mL 10 mL Flush IV access Directions: ______________ Heparin 10 units/mL for **Peripheral IV:** 3 mL 5 mL Heparin 100 units/mL for **Central IV:** 3 mL 5 mL To maintain line, flush with Heparin ______________	Normal Saline 0.9% D5W Infuse ______ mLs over ______ minutes prior to, and after Directions: ______________ ______________ ______________

Dispense all supplies needed for infusion therapy and line maintenance. Dispense one month supply. Refill 11x per year or as needed unless noted otherwise.

Signature: ______________________

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Patient: ______________________________________ DOB: _____________

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

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