

## Immune Globulins (Ig) Enrollment Form

 Fax Referral To: 1-877-232-5455
 Phone: 1-800-896-1464

 Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813
 Phone: 1-800-896-1464

IPATIENT INFORMATION (Complete or include demographic sheet)         Patient Name:         Address:	Six Simple Steps to Submitting a Referral						
Patient Name:	PATIENT INFORMATION (Complete or include demo	ographic sheet)					
Address:	-		DOB:				
Gender:       Male       Female         Preferred Contact Methods:       Prone (to primary # provided below)       Email (to email provided below)         Note:	Address:	City, State, ZIP	Code:				
Note: Carrier okarges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.         Primary Phone:	Gender: Male Female						
Primary Phone:	Preferred Contact Methods: Phone (to primary # provided be	elow) 🗌 Text (to cell # provi	ded below) 🗌 Email (to e	mail provided below)			
If Minor, Parent/Caregiver/Guardian Name (Last, First):							
Relationship to minor		Alternate Pho	one:				
Email:       Last Four of SSN:       Primary Language:         PRESCRIBER INFORMATION       State License #:         Prescriber's Name:	-						
PRESCRIBER INFORMATION         Prescriber's Name:	Relationship to minor:						
Prescriber's Name:		_ Last Four of SSN:	Primary Languag	je:			
NPI #:DEA #:Group or Hospital:	<b>2</b> PRESCRIBER INFORMATION						
Address:	Prescriber's Name:	State Lice	nse #:				
Address:	NPI #: DEA #: Group or Hospita	al:					
INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)         Insurance Company:       DB#:         DBA:       Diffice/Other         Service Location:       Ship to:       Patient   Office   Other:         Home or Coran AIC       Diluents, Flushes, Supplies, Nursing Services for drug administration/therapy teach train         MD Office/Other       Drug Only for facility administration         Diagnosis (ICD-10):       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 near-normal Immunoglobulins or with hyperimmunoglobulinemia         D81.5 Dwith low or normal B cell numbers       D81.5 Purine nucleoside phosphorylase deficiency         D81.8 Other combined immunodeficiencies       D81.9 SCID (Unspecified)         D82.0 Wiskott-Aldrich syndrome       D82.1 De George's syndrome         D83.1 Common Variable Immunodeficiency with Predominant abnormalities of B cell numbers and function         D83.2 Common Variable Immunodeficiency with Predominant tommunorgulatory T cell disorders         D83.2 Common Variable Immunodeficiency with predominant tommunorgulatory T cell disorders         D83.2 Common Variable Immunodeficiency with predominant tommunorgulatory T cell disorders         D83.2 Common Variable Immunodeficiency with predominant tommunoregula	Address:	City, State, ZIP Code:					
Insurance Company:       ID#:         IDAGNOSIS AND CLINICAL INFORMATION         Needs by Date:       Ship to:       Patient       Office       Other:	Phone: Fax Cont	act Person:	Contact's Pl	hone:			
Diagnosis AND CLINICAL INFORMATION         Needs by Date:	<b>3 INSURANCE INFORMATION</b> Please fax copy of pre	escription and insurance	cards with this form, if a	available (front and back)			
Needs by Date:	Insurance Company: ID#:						
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):	<b>4</b> DIAGNOSIS AND CLINICAL INFORMATION						
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MD Office/Other       Drug Only for facility administration         Diagnosis (ICD-10):         C 91.10 Chronic lymphocytic leukemia of B-cell type not having achieved remission         D69.3 Immune thrombocytopenic purpura       D80.0 Congenital Hypogammaglobulinemia         D80.4 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         D81.5 SCID with ow 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)         D82.4 Hyperimmunoglobuin E syndrome       D82.1 De George's syndrome         D83.0 Common Variable Immunodeficiency with Predominant abnormalities of B cell numbers and function         D83.1 Common Variable Immunodeficiency, unspecified         G11.3 Cerebellar ataxia with defective DNA       G35 MS (Relapsing Remitting)         G61.0 GBS       G70.00 MG without acute exacerbation         G70.01 MG with acute exacerbation       M33.20 Polymyositis         M33.90 Dermatomyositis       Other Code:       Description:         Patint Clinical Inf							
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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         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, unspecified         G11.3 Cerebellar ataxia with defective DNA       G35 MS (Relapsing Remitting)         G61.0 GBS       G61.81 CIDP         G61.82 MMN       G70.00 MG without acute exacerbation         M33.90 Dermatomyositis       Other Code: Description:	D80.6 Antibody deficiency with near-normal Immunoglo						
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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         D83.0 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         G61.82 MMN       G70.00 MG without acute exacerbation         G70.01 MG with acute exacerbation       M33.20 Polymyositis         M33.90 Dermatomyositis       Other Code: Description:         Patient Clinical Information:       Height: in/cm       Weight:lb/kg         History of: Headache Diabetes CHF Renal issues       Height:in/cm       Weight:lb/kg	D81.2 SCID with low or normal B cell numbers	D81.5 Purine nucleos	ide phosphorylase defi	iciency			
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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         G61.0 GBS         G61.82 MMN         G70.01 MG with acute exacerbation         M33.90 Dermatomyositis         Other Code:         Description:         Patient Clinical Information:         Allergies/rxn:         Height:         in/cm         Weight:         Lib/kg							
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G61.82 MMN       G70.00 MG without acute exacerbation         G70.01 MG with acute exacerbation       M33.20 Polymyositis         M33.90 Dermatomyositis       Other Code: Description:         Patient Clinical Information:       Height:in/cm       Weight:lb/kg         History of: Headache Diabetes CHF Renal issues       CHF       Note:			emitting)				
G70.01 MG with acute exacerbation       M33.20 Polymyositis         M33.90 Dermatomyositis       Other Code: Description:         Patient Clinical Information:       Height:in/cm         Allergies/rxn:       Height:in/cm         History of:       Headache         Diabetes       CHF         Renal issues       Keight:							
M33.90 Dermatomyositis       Other Code:Description:         Patient Clinical Information:       Height:in/cm         Allergies/rxn:       Height:in/cm         Weight:lb/kg         History of:HeadacheDiabetesCHFRenal issues		=					
Patient Clinical Information:         Allergies/rxn:							
Allergies/rxn:		Uther Code:	Description:				
History of: 🗌 Headache 🗌 Diabetes 🛄 CHF 🛄 Renal issues		Holoht in	/om 14/-	aight: lh/l/g			
			venn vve	signt:tb/ Kg			
If No, previous product used: Not the first dose given: Next dose due:		•					

		Immune Globulins (Ig) Enrollmo	ent Form		
		Please Complete Patient and Prescriber I	nformation		
Patient Name:	Patient DOB:				
Prescriber Name:	Prescriber Phone:				
<b>PRESCRIPTION</b>	INFORM	ATION Select One Immune Globulin Product:			
Asceniv 10%     Bivigam 10%     Cutaquig 16.5% (SC ro     Cuvitru 20% (SC route     Gamastan (IM route)     Route: SC IV     Directions: Daily x     Follow FDA package in     Nursing: Please arran	Goute) G Goute) G G G G G G G G G G G G G G G G G G G	ammagard Liq 10%       Gamunex-C 10         ammagard S/D       5%       10%       Hizentra 20%         ammaked 10%       Hizentra 20%         ammaplex       5%       10%       Hizentra 20%         ammaplex       5%       10%       Hizentra 20%         ther:	PFS (SC route) Panzyga 10% vials (SC route) Privigen 10% SC route) Xembify 20% (SC route) ed to the nearest vial size) erhours		
**ITEI	MS BELOW	THIS LINE WILL ONLY BE SENT FOR INFUSIONS	DONE AT HOME/CORAM AIS**		
MEDICATION	ROUTE	DOSE /STRENGTH	DIRECTIONS		
Catheter:	IV	NA	<ul> <li>Catheter Care/Flush – Only on IG drug admin days</li> <li>SASH or PRN to maintain IV access and patency</li> <li>PIV – NS 5 mL (Heparin 10 units/ mL 3-5 mL if multiple days)</li> <li>PORT/PICC – NS 10 mL &amp; Heparin 100 units/mL 3-5 mL, and/or 10 mL sterile saline to access port a cath</li> </ul>		
Hydration:	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 ** For rash or hives (If oral, patient may be instructed to purchase from retail)	PO    IV    IM	25 mg-50 mg     Peds: 1 mg/kg     Other:	<ul> <li>PRN mild/moderate allergic reaction</li> <li>Premed 30 minutes prior to infusion</li> <li>Initial dose (IV only): Administer 25 mg x 1 dose; may repeat in 3-5 minutes if needed</li> <li>Subsequent doses: may repeat every 4-6 hours as needed (Adult max 100 mg/day)</li> <li>Other:</li> </ul>		
Acetaminophen ** For aches, pain or fever (patient may purchase from retail)	PO	☐ 325 mg-650 mg ☐ Other:	Premed 30 minutes prior to infusion May repeat every 4-6 hours as needed (Adult max 2000 mg/day) Other:		
Lido/Prilocaine 2.5%/2.5% Lidocaine 4%	ТОР	30-60 grams	Apply to injection sites at least 1 hour before access Cover with occlusive dressing		
Epinephrine **home nursing requirement**	ІМ	Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) Peds 1:2000, 0.3 mL (15-30 kg/33-66 lbs) Infant 0.1 mL/0.1 mL, 0.1mL (7.5-15 kg/16.5-33lbs)	PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed		
Additional Medication:	Other:	Other:	Other:		
Quantity: 🗌 1 cycle [ RX includes related dil	1 month 1 month uents, pum	3 months Other: ps, DME, ancillary supplies as necessary for drug ac	Refills: 1 year Other:		

STAMP SIGNATURE NOT ALLOWED Patient is interested in patient support programs

Ancillary supplies and kits provided as needed for administration

## 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessar DAW / May Not Substitute <b>Prescriber's Signature:</b>	y / Do Not Substitute / No Substitution / <b>Date:</b>	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b>	Date:
CA, MA, NC & PR: Interchange is mandated unless Pr	escriber writes the words " <b>No Substitution</b> "	ATTN: New York and Iowa provid	ders, 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 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. CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the

intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

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