Immunoglobulins (Ig) Enrollment Form

Phone: 1-866-899-1661 | Email referral to: DL-NCCNewReferral@cvshealth.com
Fax enrollment form, insurance information (front/back of cards), & clinical documentation to: 1-866-843-3221

Patient Demographics:

Name _____ DOB: _____
Address _____ Last 4-SSN: _____
City, ST Zip _____ Language: _____
Email* _____ Phone* _____
Gender ☐ Male ☐ Female Alt. Phone* _____
Parent/Caregiver/Legal Guardian Name: _____
Relationship to Patient: _____ ☐ patient support program info requested

Clinical Information:

Height (in/cm) _____
Weight (lb/kg) _____
Diagnosis _____
ICD-10 Code _____
Allergies _____
Access ☐ PIV ☐ CVC/PICC ☐ Port ☐ None SC
Other _____

Date Medication Needed: _____

Site of Care:

☐ Home Infusion
☐ Coram Ambulatory Infusion Suite (AIS)
☐ Drug only to prescriber's office
☐ Drug only to other infusion clinic

Nursing: Specialty pharmacy will coordinate home health infusion nurse visit for administration and teaching.

☐ OK to administer first dose in the home if pharmacist deems appropriate
☐ Patient may be taught to self-infuse (SC)

Rx Information: Pharmacist to identify clinically appropriate Ig brand and rate per FDA guidelines. Clinically appropriate substitutions allowed based on availability or payor requirements. IV and SC dose rounded to the nearest vial size. May infuse +/- 4 days per patient schedule requests.

Drug: Immunoglobulin Route: ☐ SC ☐ IV Dose: _____ grams or _____ mg/kg daily x _____ day(s), every _____ week(s) _____
Other (Preferred Product): _____

Additional Rx Info (Home or Coram AIS): Rx includes related diluents, pumps, DME, ancillary supplies as necessary for drug administration/catheter maintenance.

Pre/Post Orders:	Dosing Protocols			Route	Directions
Normal saline hydration	**Pre:** _____mL	**Concurrent:** _____ mL Not to be infused using the same access as Ig	**Post:** _____mL	IV	Administer _____ mL/hr or over _____ hours
Diphenhydramine	☐ 25 ☐ 50 mg (May be instructed to purchase at retail.)			PO	30 minutes prior to infusion
Acetaminophen	☐ 325 ☐ 500 ☐ 650 ☐ 1000 mg (May be instructed to purchase at retail.)				
Other:					

Catheter Maintenance: Dispense and administer based on patients' current access device unless otherwise specified.

	PIV	CVC/PICC	PORT		
Saline Flush	3-5 mL	10 mL	10 mL sterile to access 10 mL Before & After	IV	Administer only on drug admin days before and after drug administration, PRN to maintain IV access patency or obtain labs.
Heparin Flush	3 mL-10 units/mL if multiple days	3-5 mL 100 units/mL excludes groshong	3-5 mL 100 units/mL		
Other:					

Anaphylaxis Orders (AIR): Dispense and administer based on current weight unless otherwise specified. Epinephrine autoinjector dispensed when self-administering.

	Adult (>30 kg)	Pediatric (15-30kg)	Infant (<15kg)		
Epinephrine	0.3 mg	0.15 mg	0.01 mg/kg *(Max 0.3mg)*	IM/SC	Administer 1 dose for moderate to severe allergic reaction. May repeat in 3-5 mins PRN.
Diphenhydramine	25-50 mg	1.25 mg/kg	1.25 mg/kg	PO	Administer x 1 dose PO for mild reaction or 1 dose slow IV/IM for moderate to severe reaction. May repeat in 3-5 mins PRN. Max dose of 50mg.
	25-50 mg	12.5 to 50 mg	1 mg/kg	IV/ IM	

Other (including O2):

AIR PROCEDURE: STOP any infusion or medication administration immediately and maintain IV access device. Assess patient response. If reaction subsides, resume infusion at ½ previous rate and increase gradually to a rate no > previous rate. If moderate to severe symptoms occur, activate EMS and initiate BCLS, O2, and AIR medications if indicated. Contact Prescriber for additional medical management if indicated. If reaction does NOT subside, continue to follow BCLS & remain with patient until EMS arrives.

Lab Orders (Home or Coram AIS only): _____ **Quantity:** ☐ 1 dose ☐ 1 month ☐ 3 months **Refills:** ☐ 1 year

Prescriber signature required (stamp not allowed): Prescriber attests to supervising this patient's medically necessary treatment.

Prescriber Name _____ NPI _____ Phone _____
State License _____ DEA _____ Fax _____
Group / Hospital _____ Contact Person _____
Address, City, ST Zip _____ Contact Phone _____

☐ 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." **NY & IA**: electronic prescription required.

*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 you by phone.
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 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.