Palmetto INFUSION

MRN:_____

DOB: _____

Order Start Date: _____

Phone: 1-800-809-1265 ext 105 Fax: 1-888-417-3658

STANDARD SubQ IG For CVID/Hypogammaglobulinemia PLAN OF TREATMENT

NOTE: We require MD office notes and may require a Letter of Medical Necessity (depending on diagnosis), to be able to verify eligibility and payment for this treatment through the patient's insurance plan.

1. Patient Name:_____Height (inches):_____Weight (lbs):_____

2. Allergies: _____

3. DIAGNOSIS: *** Please complete the 2nd and 3rd digits to complete the ICD-10 code for billing**

☐ D80.1___hypogammaglobulinemia ☐ D83._____CVID

☐ D80.2___Select IG Deficiency ☐ Other ICD-10 Code:_____Diagnosis description: _____

Orders:

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

**** DO NOT ADMINISTER SUBCUTANEOUS IG IF PATIENT'S TEMPERATURE IS GREATER THAN OR EQUAL TO 101.5 ORALLY AND NOTIFY MD.***

4. Drug: ☐ Gammagard 10%, ☐ Gamunex 10%, ☐ Gammaked 10%, or ☐ Hizentra 20%
☐ Xembify 20 %

5. Dose:_____Grams ***subcutaneous administration*** via syringe pump to infuse per protocol

6. Frequency: Every_____day (s)

7. Quantity:_____doses **Refills:** _____
Other: _____

☐ **Administer by Syringe Pump (Ambulatory Infusion Pump, Mechanical, Reusable, for subcutaneous infusion – E0779).**

☐ **Dispense supplies for external drug infusion pump, syringe type cartridge, sterile, each (K0552).**

8. Physician's Signature:_____/_____Date: _____
No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:_____**NPI:** _____

Infusion order forms available at www.palmettoinfusion.com

Revised 12/9/21

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MRN:_____

DOB: _____

Guidelines for Prescribing SubQ IG

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:** _____

☐ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-8)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include IG levels, other lab results and/or tests to support diagnosis.**

☐ If patient is currently on IVIG therapy, then please specify therapy and last dose: _____

- For patients previously on another IgG treatment, it is recommended to administer the first dose approximately one week after the last infusion of their previous treatment.

☐ Other as requested: _____

_____

Pre-Screening:

☐ **IG levels**

** Warnings/Precautions**: IgA-deficient patients with anti-IgA antibodies** are at greater risk of severe hypersensitivity and anaphylactic reactions. • **Thrombosis** may occur with immune globulin products. Risk factors may include advanced age, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling vascular catheters, hyper viscosity and cardiovascular risk factors. • **Antibodies to PH20** (Recombinant Human Hyaluronidase) can develop. The potential exists for such antibodies to cross-react with endogenous PH20 which is known to be expressed in the adult male testes, epididymis, and sperm. It is unknown whether these antibodies may interfere with fertilization in humans. • **Aseptic Meningitis Syndrome (AMS)** may occur. Discontinue treatment if AMS symptoms appear. • **Monitor for pulmonary adverse reactions** (transfusion-related acute lung injury [TRALI]). • **May carry a risk of transmitting infectious agents**, e.g., viruses, the variant Creutzfeldt-Jakob disease (vCJD) agent and, theoretically, the CreutzfeldtJakob disease (CJD) agent. • **Acute renal dysfunction/failure** has been reported in association with Immune Globulin Infusion 10% (Human) administered intravenously. Ensure that patients are not volume depleted prior to the initiation of infusion of immune globulin products. • **Hemolysis:** Monitor for clinical symptoms. • **Hyperproteinemia:** with resultant changes in serum viscosity and electrolyte imbalances may occur in patients receiving IVIG therapy. • **Volume Overload**. See full prescribing information.

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-888-417-3658 or call 1-800-809-1265 for assistance.

Revised 12/9/21