

Immunoglobulins (Ig) Enrollment Form

Fax Referral To: 1-855-297-1270Phone: 1Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

Phone: 1-888-280-1190 PR 00927 NCPDP: 4026325

Six Simple Steps to	Submitting a Referral	
PATIENT INFORMATION (Complete or include demograph	nic sheet)	
Patient Name:		Gender: 🗌 Male 🛛 Femal
Address:City	y, State, ZIP Code:	
Preferred Contact Methods: Phone (to primary # provided below) Note: Carrier charges may apply. By providing the phone number(s) and email address	s above, you are consenting to receive automa	ated calls, emails and/or text messages
from CVS Specialty [®] about your prescription(s), account, and health care. Standard da Specialty Pharmacy will attempt to contact by phone.	ita rates apply. Message frequency varies. If u	nable to contact via text or email,
Primary Phone:	Alternate Phone:	
Email: Last Four	of SSN: Primary Lang	 Juage:
Parent/Caregiver/Legal Guardian Name (Last, First):	Relationship to patient:	
2 PRESCRIBER INFORMATION		
Prescriber's Name:	State License #:	
NPI #: DEA #: Group or Hospital:		
Address: City, S Phone: Fax: Contact Po	erson: Conta	act's Phone:
INSURANCE INFORMATION Please fax copy of prescript Insurance Company: ID#:	ion and insurance cards with this fo	rm, if available (front and back
4 DIAGNOSIS AND CLINICAL INFORMATION		
Needs by Date: Ship to: Patient Office	Other:	
<u>Diagnosis (ICD-10):</u>		
ICD-10 Code: De	scription:	
Patient Clinical Information:		
Allergies/rxn:	Height:in/cm	Weight:lb/kg
History of: Headache Diabetes CHF Renal issues		
First time receiving Immunoglobulin? Yes No	If first dose, please provide IgA	
If No, previous product used:	Last dose given:	Next dose due:
PRESCRIPTION INFORMATION Select One Immunog	lobulin Product:	
Asceniv 10%	Gamunex-C 10%	🗌 Octagam 🗌 5% 🔲 10%
Bivigam 10% Gammagard S/D 5% 10%	Hizentra 20% PFS (SC route)	Panzyga 10%
Cutaquig 16.5% (SC route) Gammaked 10%	Hizentra 20% vials (SC route)	Privigen 10%
Cuvitru 20% (SC route)	🗌 HyQvia 10% (SC route)	Xembify 20% (SC route)
Gamastan (IM route) Other:		• • • • • •
	g (dose will be rounded to the nearest v	ial size)
Directions: Daily x Day (s), every Week Other: Follow FDA package insert infusion rate directions Infuse at ma	x rate of mL/hr	
Nursing: Specialty pharmacy to coordinate home health infusion nurse vis		
Site of Care: Home Infusion* Coram Ambulatory Infusion Suite (AIS)		usion Clinic
*Home Infusion/Coram AIS: Diluents, Flushes, Supplies, Nursing Services,		
**Prescriber's Office/Other Infusion Clinic:		
Drug only for facility administration: OK to administer first dose in the he infuse (SC)	ome if pharmacy deems appropriate	Patient may be taught to self-
Lab Orders: (Only if IV and Site of Care is Home/AIS):		
Dressed to pay tagge to complete form		

Proceed to next page to complete form



Scan code or visit cvs.co/ig-comparison

Immunoalobulins (Ia) Enrollment Form

Catheter IV N/A SASH PIV PORT IV N/A CVC// Cock/PICC IV N/A CVC// Hydration: Cock/PICC IV Pre: 500 mL 1000 mL Other: Hydration: Mydration: IV Pre: 500 mL 1000 mL Other: Hydration: Image: Cock of the same access as [g) Post S00 mL 1000 mL Other: Hydration: Image: Cock of the same access as [g) Post S00 mL 1000 mL Other: Image: Cock of the same access as [g) Post S00 mL 1000 mL Other: Image: Cock of the same access as [g) Post Image: Cock of the same access as [g) Post Image: Cock of the same access as [g) Post Image: Cock of the same access as [g) Post Image: Cock of the same access as [g) Post Image: Cock of the same access as [g) Post Image: Cock of the same access as [g) Post Image: Cock of the same access as [g) Post Image: Cock of the same access as [g) Post Image: Cock of the same access as [g) Post Image: Cock of the same access as [g) Post Image: Cock of the same acces as	tion	
Prescriber Name: Prescriber Name: Prescriber Name: PRESCRIPTION INFORMATION **ITEMS BELOW THIS LINE WILL ONLY BE SENT FOR MEDICATION ROUTE DOSE/STRENGTH Catheter N/A Cathe PIV PORT IV N/A CVC/PICC IV N/A CVC// Hydration: V N/A CVC// Other Pre: 500 mL 1000 mL Other: Hydration: V N/A Concurrent: 1000 mL Other: (Adult) Other Pre: 500 mL 1000 mL Other: PR Diphenhydramine (patient may be instructed to purchase from retail) PPO 25 mg-50 mg may prescient may be instructed to purchase PO Peds: 1 mg/kg Su as a set mg/d Other: PPO 25 mg-650 mg Prescient may be instructed to purchase PO Peds: 10-15 mg/kg Adult Suff-Orthroscine PO 30-60 grams Cover Cover Cutdor/Prilocaine PO Stam grafs and g		
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Hydration: W/ hu Hydration: Pre: 500 mL 1000 mL Other: (Adduti indica may be instructed to purchase from retail) PPO 25 mg-50 mg Pre: (Adduti indica may be instructed to purchase from retail) PPO Pre: (Addution Pre:	NS 5 mL (Heparin 10 units/ml 3-5 mL if ple days) /PICC: NS 10 mL & Heparin 10 units/mL or units/mL 3-5 mL	
Hydration: IV Pre: □ 500 mL □ 1000 mL □ 0ther: (Additional McLick of the same access as Ig) Hydration: (Additional McLick of the same access as Ig) Hydration: (Additional McLick of the same access as Ig) Hydration: (Additional McLick of the same access as Ig) Hydration: (Additional McLick of the same access as Ig) Hydration: (Additional McLick of the same access as Ig) Hydration: (Additional McLick of the same access as Ig) Hydration: (Additional McLick of the same access as Ig) Hydration: (Additional McLick of the same access as Ig) Hydration: (Additional McLick of the same access as Ig) Hydration: (Additional McLick of the same access as Ig) Hydration: (Additional McLick of the same access as Ig) Hydration: (Additional McLick of the same access as Ig) Hydration: (Additional McLick of the same access as Ig) Hydrational Milled-Image access as Ig) Hydrational Milled-Image access as Ig) Hydrational McLick of the same access as Ig) Hydrational Milled-Image access as Ig) Hydrational Milled-Image access as Ig) Hydrational Milled-Image access as Ig) Hydrational McLick of the same access as Ig) Hydrational Milled-Image access as Ig) Hydrational Milled-Image access as Ig) Hydrational McLick of the same access as Ig) Hydrational McLick of the same access as Ig) Hydrational Milled-Image access accover Image access access access accover Image access ac	F: 10 mL sterile saline to access PORT uber needle NS 10 mL & Heparin 100 units/mL 3-5 mL	
□ Diphenhydramine (patient may be instructed to purchase from retail) □ PO □ IV □ 25 mg-50 mg □ Peds: 1 mg/kg □ Ini may rm g Su □ Other: □ Acetaminophen (patient may be instructed to purchase from retail) □ Ot □ 325 mg-650 mg □ Peds: 10-15 mg/kg □ Pr M Ma a Ches □ Other: □ Lido/Prilocaine 2.5%/2.5% PO □ 325 mg-650 mg □ Peds: 10-15 mg/kg □ Pr M Ma a Ches □ Other: □ Lido/Prilocaine 2.5%/2.5% TOP 30-60 grams Cover Cover □ Epinephrine **nursing requires** □ IM □ SC □ 1:1000, 0.3 mg/ 0.3 mL (Jf-30 kg/33-66lbs) Mild-1 minut For se □ 1:1000, 0.01 mg/kg, Max 0.3 mg (under 15 kg) Mild-1 minut For se □ Additional Medication: Other: Other: Other: Other □ Additional Medication: Other: Other: Other Other □ Additional Medication: Other: Other: Other □ Matints: 1 nonth □ 3 months □ Other:: Refills: □ 1 yo Other Other □ Prescriber SignATURE REQUIRED (STAMP SignATURE NOT ALLOWE) May Substitute / Product S StAMP SignAture / Brand Medically Necessary / Do Not Substitute / No Substitute / Product S Statute / Product S	ation max infusion rate mL/hr It max rate 250 mL/hr unless otherwise	
(patient may be instructed to purchase from retail) PO Peds: 10-15 mg/kg Ma Deds: 10-15 mg/kg Other: Other: Other: Other: 1 Lido/Prilocaine Apply 2.5%/2.5% TOP 30-60 grams Apply 1 Lidocaine 4% Cover Cover 2.5%/2.5% TOP 30-60 grams Cover 1 Lidocaine 4% Image: Cover Cover 2.5%/2.5% SC 1:1000, 0.3 mg/ 0.3 mL (greater than 30 kg/66lbs) Mild-1 **nursing requires** SC 1:2000, 0.15 mg/0.3 mL (15-30 kg/33-66lbs) minut **nursing requires** SC 1:1000, 0.01 mg/kg, Max 0.3 mg (under 15 kg) For se Additional Other: Other: Other Medication: Other: Other: Other		
Lido/Prilocaine Apply 2.5%/2.5% TOP 30-60 grams Access Lidocaine 4% Image: constraint of the state of th	remed 30 minutes prior to infusion lay repeat every 4-6 hours as needed for s, pain, or fever (Adult max 2000 mg/day) ther:	
Lipinephrine IM 1:2000, 0.15 mg/0.3 mL (15-30 kg/33-66lbs) minut **nursing requires** SC 1:1000, 0.01 mg/kg, Max 0.3 mg (under 15 kg) For set Additional Other: Other: Other: Other: Other: Medication: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Duantity: 1 cycle 1 month 3 months Other: Refills: 1 yet X includes related diluents, pumps, DME, ancillary supplies as necessary for drug administration/cather Patient is interested in patient support programs STAMP SIGNATURE NOT ALLOWED An PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED An "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product S Substitute / Product S Substitution Permissible	y to injection sites at least 1 hour before	
Medication:	Moderate Reactions. May repeat in 3-5 tes as needed evere allergic reaction also call 911	
Other: Other: Other: Other: Other: Other: Other: Image: Constraint of the state of the stat	r:	
Notes:	r:	
Quantity: 1 cycle 1 month 3 months Other: Refills: 1 yet XX includes related diluents, pumps, DME, ancillary supplies as necessary for drug administration/cather STAMP SIGNATURE NOT ALLOWED An Patient is interested in patient support programs STAMP SIGNATURE NOT ALLOWED An PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED An "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product S DAW / May Not Substitute Substitute / No Substitution / May Substitute / Product S	r:	
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"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product S DAW / May Not Substitute Substitute	WED)	
Prescriber's Signature: Date: Prescriber's Signatu	Selection Permitted /	
Prescriber's Signature:Dat		
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" ATTN: New N	York and Iowa providers, please submit electronic prescript	

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 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.

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