Subcutaneous Immune Globulin / Allergy

Please complete and attach to MDX prior Authorization form

PATIENT INFORMATION:	PHYSICIAN INFORMATION:
Patient Name:	Physician Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Home Phone: Alternate Phone:	Phone: Fax:
Email:	Office Email:
Soc. Sec #: Weight: ____ ☐kg ☐lbs Height: ____☐ft ☐cm	Key Office Contact:
Date of Birth: Sex: ☐ Male ☐ Female BMI: ____	State LIC # NPI # DEA#

INSURANCE INFORMATION: ☐ DEMOGRAPHIC SHEET ☐ UNIVERSAL CLAIM FORM ☐ INSURANCE CARDS (front + back)

*Please include demographic sheet along with Universal Claim Form for insurance records or reimbursement. (Attach Copies of cards)

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization

Diagnosis / ICD-10: Date of Diagnosis:	Has patient received immune globulin previously? ☐ Yes ☐ No
IgA deficiency: ☐ Yes ☐ No IgA level mg/dL Date:	If yes, product information:
Comorbidities:	Date of last infusion: Date of next infusion:
Concomitant Medications:	
Allergies: ☐ NKDA ☐ Other:	

MEDICATIONS AND DIRECTIONS

MEDICATION	DOSAGE & DIRECTIONS	QUANTITY	REFILL
☐ **Hizentra® 20%**			
Number of sites: ___________	Rate: ☐ Per manufacture guidelines, as tolerated ☐ ____________ Weekly SC dose = IVIG Dose (g) x 1.3 / IVIG weekly interval originally given		
☐ **Gammaked™ 10%**			
☐ **Gammagard liquid® 10%**			
☐ **Gamunex-C®**			
Number of sites: ___________	Rate: ☐ Per manufacture guidelines, as tolerated ☐ ____________ Weekly SC dose = IVIG Dose (g) x 1.3 / IVIG weekly interval originally given		
☐ **HyQvia® 10%**	Please complete and attach HyQvia Prescription Referral form which can be located at: http://www.hyqviahcp.com		
☐ **Premedication**	Acetaminophen ______ mg ☐ Premedication 30 minutes prior to infusion. ☐ Post infusion every 4-6 hours as needed for fever/headache.		
	Diphenhydramine ______ mg ☐ Premedication 30 minutes prior to infusion. ☐ Post infusion every 4-6 hours as needed for itching/site reactions.		
	☐ Lidocaine 2.5% and Prilocaine 2.5% Cream 30 grams. Apply small amount topically to insertion site(s) prior to needle insertion as needed.		
	Drug: Strength: Directions:		
☐ **Anaphylaxis Order & Medication**	Orders: 1. Stop infusion 2. Call 911 and prescribing physician 3. Administer medications below as per protocol		
	Epinephrine Auto-injector: ☐ Administer 0.15 mg (15 - 30 kg) IM or subcut as needed ☐ Administer 0.3 mg (≥ 30 kg) IM or subcut as needed		
☐ **Ancillary Supplies & Equipment**	Syringe driver/pump(s) and supplies provided as needed for administration and appropriate disposal of infusion materials.		
☐ **Skilled Nursing Visits**	To train patient/caregiver in Subcutaneous Immune Globulin administration, provide education related to disease state/therapy and assess general status. Typically, 2-4 training visits required. Once trained and able to return demonstrate, patient/caregiver to self-administer Subcutaneous Immune Globulin medication independently unless otherwise specified.		

MEDICATION & STRENGTH	DOSAGE & DIRECTIONS	QUANTITY	REFILL
	Atopic Dermatitis		
☐ **Dupixent®**	☐ 300mg/2ml PFS. Initial dose 600mg (2 syringes) SQ followed by 300mg (1 syringe) SQ every 2 weeks.	☐ 28 day Supply	
	Severe Asthma		
☐ **NUCALA® (mepolizumab) 100 mg Vial**	inject 100 mg subcutaneously once very 4 weeks into the upper arm, thigh or abdomen ☐ Include Sterile water and supplies sufficient for medication days supply • One 10 mL vial sterile water for injection for every vial of Nucala dispensed • Alcohol swabs • 3 mL Luer Lock injection syringe • NDL 21G needle for reconstitution • 1 mL polyprophylene syringe with 21G to 27G x 1/2" needle for subcutaneous injection ☐ No supplies (the above supplies will be sent with shipment unless indicated)	☐ 30 day Supply ☐ 90 day Supply ☐ ___ day Supply	☐ 1 Year ☐ ______
☐ **Others**			

Prescriber Signature Required ***Prescription is void if the number of drugs prescribed is not noted**

I authorize Hawaii Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Prescriber Signature	Date	NO. OF DRUGS PRESCRIBED __________ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
X		

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