



# HOME PARENTERAL SERVICES

## Subcutaneous Immune Globulin

PHONE: **1-800-637-9201**  
FAX: **1-417-269-0692**

Patient information		Prescriber + Shipping Information																																	
Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SS #: _____ 1° Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate Phone: _____ Caregiver name: _____ Relation: _____ Local Pharmacy: _____ Phone: _____		Prescriber Name: _____ NPI #: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email address: _____ If shipping to prescriber: <input type="checkbox"/> 1st Fill <input type="checkbox"/> Always <input type="checkbox"/> Never																																	
Insurance Information (Please fax a copy of front and back of the insurance cards)																																			
1° Insurance Plan: _____ Plan ID #: _____ 2° Insurance Plan: _____ Plan ID #: _____		Policy Holder: _____ Relation: _____ Policy Holder: _____ Relation: _____																																	
Clinical Information (Please fax all pertinent clinical and lab information)																																			
<b>ICD-10/Diagnosis Code:</b> _____ Date of Diagnosis: _____ IgA deficiency: <input type="checkbox"/> Yes <input type="checkbox"/> No IgA level _____ mg/dL Date: _____ IgG trough: _____ mg/dL Date: _____ Diabetic: <input type="checkbox"/> Yes <input type="checkbox"/> No Comorbidities: _____ Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____																																			
Has patient received immune globulin previously? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, product information: _____ Date of last infusion: _____ Date of next infusion: _____																																			
Prescription	Drug	Dose and Directions	Quantity	Refills																															
Immune Globulin Products	<input type="checkbox"/> Pharmacy to determine <input type="checkbox"/> Cuvitru 20% <input type="checkbox"/> Hizentra 20% <input type="checkbox"/> Gammagard 10% <input type="checkbox"/> Gammaked 10% <small>for Primary Immunodeficiency indication only</small> <input type="checkbox"/> Gamunex-C 10% Other: _____	Infuse _____ grams subq every _____ days.  OR  <input type="checkbox"/> Other: _____ _____  Rate: per manufacturer's guidelines OR Other: _____ _____	28 days supply	_____																															
	<input type="checkbox"/> HyQvia 10%	<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th>Week</th> <th>Infusion Number</th> <th>Dose Interval</th> <th>Dose</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>1<sup>st</sup> infusion</td> <td>1-week-dose</td> <td>__ grams</td> </tr> <tr> <td>2</td> <td>2<sup>nd</sup> infusion</td> <td>2-week dose</td> <td>__ grams</td> </tr> <tr> <td>3</td> <td colspan="3" style="background-color: black; color: white;">No infusion</td> </tr> <tr> <td>4</td> <td>3<sup>rd</sup> infusion</td> <td>3-week-dose</td> <td>__ grams</td> </tr> <tr> <td>5</td> <td colspan="3" style="background-color: black; color: white;">No infusion</td> </tr> <tr> <td>6</td> <td colspan="3" style="background-color: black; color: white;">No infusion</td> </tr> <tr> <td>7</td> <td>4<sup>th</sup> infusion (if required)</td> <td>4-week-dose</td> <td>__ grams</td> </tr> </tbody> </table> Goal dose: _____ grams subq every _____ weeks  Rate: per manufacturer's guidelines OR Other: _____ _____	Week	Infusion Number	Dose Interval	Dose	1	1 <sup>st</sup> infusion	1-week-dose	__ grams	2	2 <sup>nd</sup> infusion	2-week dose	__ grams	3	No infusion			4	3 <sup>rd</sup> infusion	3-week-dose	__ grams	5	No infusion			6	No infusion			7	4 <sup>th</sup> infusion (if required)	4-week-dose	__ grams	21-28 days supply as applicable
Week	Infusion Number	Dose Interval	Dose																																
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4	3 <sup>rd</sup> infusion	3-week-dose	__ grams																																
5	No infusion																																		
6	No infusion																																		
7	4 <sup>th</sup> infusion (if required)	4-week-dose	__ grams																																
Other Medications	<input type="checkbox"/> Acetaminophen _____ mg PO 15-30 minutes prior to infusion <input type="checkbox"/> Diphenhydramine _____ mg PO 15-30 minutes prior to infusion <input type="checkbox"/> Other: _____																																		
Skilled Nursing Visits	Skilled Nursing visit to teach self administration of subcutaneous infusion and prn if needed																																		
<div style="display: flex; justify-content: space-between;"> <div>           Prescriber's Signature: _____  <div style="display: flex; justify-content: space-around; width: 100%;"> <span>Substitution Permitted</span> <span>Dispense as Written</span> </div> </div> <div>           Date: _____         </div> </div> <p style="font-size: small; margin-top: 10px;">I authorize Home Parenteral Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Home Parenteral Services.</p>																																			

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