HOME PARENTERAL SERVICES

Subcutaneous Immune Globulin

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

Patient information

Patient Name: _____ DOB: _____
Sex: ❑ Female ❑ Male SS #: _____
1˚ Language: _____ Wt:_____ ❑ kg ❑ lbs Ht:_____ ❑ cm ❑ in
Address: _____
Apt/Suite: _____ City:_____ State:_____ Zip:_____
Phone:_____ Alternate Phone:_____
Caregiver name: _____ Relation: _____
Local Pharmacy: _____ Phone: _____

Prescriber + Shipping Information

Prescriber Name:_____
NPI #: _____
Address: _____
Apt/Suite: _____ City:_____ State:_____ Zip:_____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email address: _____
If shipping to presciber: ❑ 1st Fill ❑ Always ❑ Never

Insurance Information (Please fax a copy of front and back of the insurance cards)

1˚ Insurance Plan: _____ Plan ID # _____ Policy Holder: _____ Relation: _____
2˚ Insurance Plan: _____ Plan ID # _____ Policy Holder: _____ Relation: _____

Clinical Information (Please fax all pertinent clinical and lab information)

ICD-10/Diagnosis Code: _____
Date of Diagnosis: _____
IgA deficiency: ❑ Yes ❑ No IgA level _____ mg/dL Date:_____
IgG trough:_____mg/dL Date:_____ Diabetic: ❑ Yes ❑ No
Has patient received immune globulin previously? ❑ Yes ❑ No
If yes, product information: _____
Date of last infusion: _____ Date of next infusion: _____
Comorbidities: _____
Allergies: ❑ NKDA ❑ Other: _____

Prescription

Immune Globulin Products

Drug

❑ Pharmacy to determine
❑ Cuvitru 20%
❑ Hizentra 20%
❑ Gammagard 10%
❑ Gammaked 10%
for Primary Immunodeficiency indication only
❑ Gamunex-C 10%
Other: _____

Dose and Directions

Infuse _____ grams subq every ____ days.

OR

❑ Other: _____
_____

Rate: per manufacturer's guidelines OR Other: _____
_____

Quantity: 28 days supply

Refills: _____

Drug

❑ HyQvia 10%

Dose and Directions

Week	Infusion Number	Dose Interval	Dose
1	1st infusion	1-week-dose	__ grams
2	2nd infusion	2-week dose	__ grams
3		No infusion	
4	3rd infusion	3-week-dose	__ grams
5		No infusion	
6		No infusion	
7	4th infusion (if required)	4-week-dose	__ grams

Goal dose: _____ grams subq every ___ weeks

Rate: per manufacturer's guidelines OR Other: _____
_____

Quantity: 21-28 days supply as applicable

Refills: _____

Other Medications

❑ Acetaminophen ____ mg PO 15-30 minutes prior to infusion
❑ Diphenhydramine ____ mg PO 15-30 minutes prior to infusion
❑ Other: _____

Skilled Nursing Visits

Skilled Nursing visit to teach self administration of subcutaneous infusion and prn if needed

Prescriber's Signature:_____ _____ Date: _____
Substitution Permitted Dispense as Written

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.