Carepoint™

A Pharmacy That Truly Cares

Immunoglobulin Therapy Enrollment

www.carepointrx.com

Fax: 855-237-9113 | Toll Free: 855-237-9112

E-Prescribe: NCPDP 1487330 | NPI 1598013864

PATIENT

PLEASE INCLUDE FACE SHEET & ALL INSURANCE CARDS

Name ____ DOB ___________________ Phone __________________________

Address ____ City, State ______________________________ Zip _____________

MEDICAL ASSESSMENT

DATE: __________________ Height & Weight: _________________ Allergies: _______________________________________

ICD-10 code & description(s): ☐ ______________________________________ ☐ ______________________________________

IgA deficiency: ☐ Yes ☐ No **IgA level:** _________ mg/dL **Date:** ________________ **Access:** ☐ Peripheral Line ☐ Implant Port

Diabetic: ☐ Yes ☐ No **IgG tough:** ________ mg/dL **Date:** ________________ ☐ N/A ☐ Broviac/Hickman ☐ PICC

Previous Ig therapy? ☐ N/A **Product:** ___________________ **Last infusion date:** _________________ **Next infusion:** _________________

PRESCRIPTION

Immunoglobulin Therapy ☐ Clinical Pharmacist to determine appropriate product

Intravenous *(via ambulatory pump)*			**Subcutaneous**
☐ Bivigam	☐ Gamastan S/D	☐ Gamunex-C	☐ Hizentra
☐ Carimune NF	☐ Gammagard	☐ Octagam	☐ Hyqvia
☐ Flebogamma 5%	☐ Gammaked	☐ Privigen	☐
☐ Flebogamma 10%	☐ Gammaplex	☐	☐

Regimen: _______ grams/kilogram daily for _______ day(s) REPEAT every _______ week(s) for _______ doses

Total Dose: ________________________ Refills: ________________________

Medications and Protocols: **Quantity/Refills:**

Acetaminophen	☐ 325mg ☐ 500mg ☐ PRN ☐ By mouth 30 min. before infusion	4 weeks / 1 year
Diphenhydramine	☐ 25mg ☐ PO ☐ IV ☐ 30 minutes before infusion ☐ 50mg ☐ PRN allergic reaction	4 weeks / 1 year
Normal Saline Flush	☐ 3-5mL per SASH protocol	4 weeks / 1 year
Heparin 100u/mL push	☐ 3-5mL per SASH protocol	4 weeks / 1 year
EpiPen 2-pack	☐ Use as directed for anaphylaxis	4 weeks / 1 year
0.9% NaCl Hydration	☐ 500mL ☐ PRIOR to infusion ☐ DURING infusion ☐ 1000mL ☐ POST infusion ☐ PRN	4 weeks / 1 year
OTHER: __________________	Sig: ____	______ / ______

☒ Dispense sufficient quantity of all necessary supplies (gloves, syringes, needles, alcohol wipes, etc.) for proper medication administration

Required Documentation: ✓ BUN/creatinine ✓ Labs to be drawn every _______ weeks

(Current within 90 days) ✓ Immunoglobulin panel

☐ ***Carepoint Healthcare to coordinate and schedule all home nursing, infusion & billing services on behalf of patient***

PROVIDER

PLEASE INCLUDE ALL RECENT LABS & CLINICAL NOTES

Prescriber Name ______________________________________ Phone ____________________ Fax ____________________

___________________________________ (___________________) ____________________________________

Prescriber Signature ***NPI or DEA*** ***In-Office Contact Person***

**By signing this form and utilizing our services, you authorize Carepoint and its employees to serve as your designated agent for handling prior authorizations and other medical and prescription insurance forms and communications*