Please fax both pages of completed form to your drug therapy team at 866.233.7151.
To reach your team, call toll-free 866.820.IVIG (866.820.4844).

Prescription & Enrollment Form
Intravenous immune globulin (IVIG)

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Four simple steps to submit your referral.

☐ Do not contact patient, benefits check only

1 Patient Information

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

Sex at birth: ☐ Male ☐ Female Preferred pronouns _____ Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Patient's primary language: ☐ English ☐ Other If other, please specify _____

Please provide copies of front and back of all medical and prescription insurance cards.

2 Prescriber Information

Date _____ Time _____ Date medication needed _____

Office/clinic/institution name _____

Prescriber info: Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact email _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name _____ Clinic/hospital affiliation _____

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion site contact _____ Phone _____ Fax _____ Email _____

3 Clinical Information

CHECK ONE

ICD-10 immunology: ☐ D80.0 Congenital Hypogam ☐ D83.9 CVID (unspecified) ☐ D81.9 SCID (unspecified)
ICD-10 neurology: ☐ G61.81 CIDP ☐ G61.82 MMN ☐ G35 MS (rel remit) ☐ G61.0 GBS ☐ G70.01 MG
ICD-10 rheumatology: ☐ M33.20 Polymyositis ☐ M33.90 Dermatomyositis
☐ **Other** _____

Other drugs used to treat the disease _____

Weight _____ kg/lbs Height _____ cm/in Date recorded _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Adverse reactions with previous IG treatments? _____

If so, what brand of IVIG caused the reaction? _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/Formulation	Directions
Select one preferred IVIG brand-name products you have authorized and are clinically appropriate for your specific patient. Single drug selection required for Medicare Part B		
Select one or multiple choices ☐ Bivigam® 10% ☐ Gammagard® liquid 10% ☐ Gammagard® S/D 5% ☐ Gammagard® S/D 10% ☐ Gammaked™ 10% ☐ Gammaplex® 5% ☐ Gammaplex® 10% ☐ Gamunex®-C 10% ☐ Octagam® 5% ☐ Octagam® 10% ☐ Panzyga® 10% ☐ Privigen® 10% ☐ Any brand ☐ Other _____	Infuse _____ grams OR _____ grams per kg OR _____ mg per kg intravenously every _____ weeks ☐ Divide total dose over _____ days (where clinically appropriate, round to the nearest vial size)	**Rate protocol:** Titrate initial and maintenance infusions per manufacturer's product labeling. **Vascular access:** ☐ Peripheral ☐ Central ☐ Port **Infusion method:** ☐ Gravity ☐ Pump

You have indicated which medication(s) are prescribed for this patient. You acknowledge that each medication selected is clinically appropriate for the patient. Signing this form authorizes Accredo to dispense one prescribed medication from your selection above based upon information available to Accredo, including clinical information, insurance requirements, and medication availability at the start of therapy and for the duration of this valid prescription. Accredo will communicate to you the medication dispensed to your patient. Dispensing confirmation and status updates will also be available at **MyAccredoPatients.com**.

Premedication to be given 30 minutes prior to infusion: *(please strike through if not required)*
- Diphenhydramine 25mg by mouth for mild infusion reactions, may increase to 50mg for history of moderate to severe (contraindicated in patients with myasthenia gravis)
- Acetaminophen 650mg by mouth

☐ Other _____

For patients weighing less than 60kg, the following weight-based dosing range will be used: Acetaminophen: 10–15mg/kg

For pediatric patients, the following weight- and age-based dosing range will be used:
≤9kg and/or <2 years old: Diphenhydramine 1mg/kg up to max of 6.25mg
2–5 years old and >9kg: Diphenhydramine 6.25mg to 12.5mg
6–12 years old: Diphenhydramine 12.5 to 25mg

Medications to be used as needed: *(please strike through if not required)*
- Diphenhydramine 25mg by mouth every 4–6 hours as needed for mild infusion reactions, may increase to 50mg for moderate to severe; maximum of 4 doses per day (contraindicated in patients with myasthenia gravis)
- Lidocaine 4% applied topically to insertion site prior to needle insertion as needed to prevent site pain
- Acetaminophen 650mg by mouth every 4–6 hours as needed for fever, headache or chills; maximum of 4 doses per day

Adverse reaction medications: *(keep on hand at all times)*
- Epinephrine 0.3mg auto-injector 2-pk for patients weighing greater than or equal to 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose
- Epinephrine 0.15mg auto-injector 2-pk for patients weighing less than 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose
- Diphenhydramine 25mg by mouth for mild allergic reactions and 50mg for moderate to severe

CHECK HERE

Hydration
Medication: ☐ 0.9% Normal Saline _____ mL infused over _____ minutes ☐ D5W _____ mL infused over _____ minutes
Timing: ☐ Pre-IG infusion _____ minutes before ☐ Post-IG infusion ☐ To be completed during the IVIG infusion

Flushing orders:
- 0.9% Normal Saline 3mL intravenous (peripheral line) or 10mL intravenous (central line) before and after infusion, or as needed for line patency
- Heparin 10 units per mL 3mL intravenous (peripheral line) as needed for final flush
- Heparin 100 units per mL 5mL intravenous (central line) as needed for final flush

Supplies: *(please strike through if not required)*
Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

Quantity/Refills: ☐ 1-month supply. Refill x 1 year unless noted otherwise. ☐ 90-day supply. Refill x 1 year unless noted otherwise.
☐ Other _____

Lab orders _____

Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy.

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature required (sign below): (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ **Date**

_____ **Dispense as written**

_____ **Date**

_____ **Substitution allowed**

☐ Pharmacist selection allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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Prior authorization checklist
Primary immune deficiency disease (PIDD)

Providing Accredo with the documentation outlined in this checklist may increase the likelihood and speed of obtaining coverage for your patients with PIDD. Coverage criteria may vary by payer.

Referral form[1] (not required for electronic prescriptions)	
	Completed Immunoglobulin (Ig) referral form (available at **accredo.com**)
	Copies of the front and back of all medical insurance and prescription benefits cards
Clinical documents	
	History and Physical (H&P) and progress notes (within past 6 months) Note: H&P to include documented infection history/treatment
	Pre-treatment IgG, IgA, IgM, and Ig subclass serum levels (drawn on two different occasions when available) Current IgG, IgA, IgM, and Ig subclass serum levels
	Pre- and post-antigen testing (tetanus, pneumococcal polysaccharide or H Influenza type B) AND documentation of vaccine administration date

Medicare-approved PIDD diagnosis
Immunodeficiency with predominantly antibody defects
D80.0 – Hereditary hypogammaglobulinemia
D80.2 – Selective deficiency of immunoglobulin A (IgA)
D80.3 – Selective deficiency of immunoglobulin G (IgG) subclasses
D80.4 – Selective deficiency of immunoglobulin M (IgM)
D80.5 – Immunodeficiency with increased immunoglobulin M (IgM)
D80.6 – Antibody deficiency with near-normal immunoglobulins or with hyperimmunoglobulinemia
D80.7 – Transient hypogammaglobulinemia of infancy
Combined immunodeficiencies
D81.0 – Severe combined immunodeficiency (SCID) with reticular dysgenesis
D81.1 – Severe combined immunodeficiency (SCID) with low T- and B-cell numbers
D81.2 – Severe combined immunodeficiency (SCID) with low or normal B-cell numbers
D81.5 – Purine nucleoside phosphorylase (PNP) deficiency
D81.6 – Major histocompatibility complex class I deficiency
D81.7 – Major histocompatibility complex class II deficiency
D81.89 – Other combined immunodeficiencies
D81.9 – Combined immunodeficiency, unspecified
Immunodeficiency associated with other major defects
D82.0 – Wiskott-Aldrich syndrome
D82.1 – Di George's syndrome
D82.4 – Hyperimmunoglobulin E (IgE) syndrome
Common variable immunodeficiency (CVID)
D83.0 – CVID with predominant abnormalities of B-cell numbers and function
D83.1 – CVID with predominant immunoregulatory T-cell disorders
D83.2 – CVID with autoantibodies to B- or T-cells
D83.8 – Other CVIDs
D83.9 – CVID unspecified
Other
G11.3 – Cerebellar ataxia with defective DNA repair
*G61.81 – Chronic inflammatory demyelinating polyneuritis (CIDP)

Fax completed form to 866.233.7151.

If you have any questions, please call your Accredo Provider Support Advocate, or call 866.820.4844.

1 For referral forms visit accredo.com.
* Hizentra® (immune globulin subcutaneous, human, 20% liquid) was approved by Medicare Part B for the treatment of chronic inflammatory demyelinating polyneuropathy (CIDP) effective July 19, 2021.

IGL-00090 AMC21004 CRP2202_0014481.1

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Prior Authorization Checklist
Neuromuscular Disorders[1]

Providing Accredo with the documentation outlined in this checklist may increase the likelihood and speed of obtaining coverage for your patients. Coverage criteria many vary by payer.

Referral Form (not required for electronic prescriptions)	
	Completed Immunoglobulin (Ig) referral form (available at accredo.com)
	Copies of the front and back of all medical insurance and prescription benefits cards
Clinical Documents	
	History and Physical (H&P) and progress notes[2] (within past 6 months) Note: Diagnosis of the disorder must be unequivocal
	Documentation that other causes of demyelinating neuropathy have been excluded

Testing documentation:

- ☐ Electrophysiological motor-sensory nerve conductions
- ☐ Electromyography (EMG)
- ☐ Cerebrospinal fluid (CSF)
- ☐ Biopsy (muscle-nerve) - if necessary

Additional Requirements for Myasthenia Gravis	
	Tensilon test results
	Refractory to corticosteroids over a 6 month period documentation
	Ongoing Ig treatment must be documented in H&P and progress notes[2]
Additional Requirements for Polymyositis and Dermatomyositis Diagnosis	
	Creatine phosphokinase (CPK) values
	Electromyography (EMG) and/or muscle biopsy results

1 This Neuromuscular Disorders checklist is based on Medicare Part B guidelines related to Guillain-Barre' syndrome (GBS), relapsing-remitting multiple sclerosis, chronic inflammatory demyelinating polyneuropathy (CIDP) (and variant syndromes such as Multifocal Motor Neuropathy (MMN)), myasthenia gravis, refractory polymyositis, and refractory dermatomyositis polymyositis, and refractory dermatomyositis

2 Ongoing management and documentation requirements:
- Initial improvement and continued need must be meticulously documented in progress notes
- All weaning must be attempted and documented as either amount or frequency
- Must be a stoppage in IVIG if sustained improvement is noted with weaning or no improvement has taken place at all

Fax completed form to 866.233.7151.

If you have any questions, please call your Accredo Provider Support Advocate, or call 866.820.4844.

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