To reach your team, call toll-free 650.808.6488 (toll-free).

Prescription & Enrollment Form

Subcutaneous immune globulin (SCIG)



Four simple steps to submit your referral.

Do not contact patient, benefits check only		
1 Patient Information		
New 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		·
Parent/guardian (if applicable)		
Patient's primary language: English Other If other	er, please specify	
Please attach copies of front and back of patient	t's insurance cards.	
nsurance Company		Phone
dentification #		
Prescription card: Yes No If yes, carrier	Policy #:	Group #
2 Prescriber Information		
Date Time	Date medication needed _	
Office/clinic/institution name		
Prescriber info: Prescriber's first name	Last name .	
Prescriber's title		
Office phone Fax	NPI #	License #
Office contact and title	Office contac	t email
Office street address		Suite #
City		•
nfusion location: Patient's home Prescriber's office	Infusion site If infusion site, complete	
nfusion info: Infusion site name	Clinic/hospital affiliation	on
Site street address		Suite #
City		•
nfusion site contact Phone	Fax	Email
3 Clinical Information	Fax	Email
ICD-10 immunology: D80.0 Congenital Hypoga ICD-10 neurology: G61.81 CIDP G61.82 N ICD-10 rheumatology: M33.20 Polymyositis Other	MMN G35 MS (rel remit) G61.0 M33.90 Dermatomyositis	31.9 SCID (unspecified) GBS G70.01 MG
Other drugs used to treat the disease		
Weight kg/lbs Height		
NKDA Known drug allergies		
Concurrent meds		

Patient's first name	Last name	Middle initial	Date of birth
Prescriber's first name	Last name	Phone	

4

or mu

Prescribing Information

Medication		Strength/Fo	rmulation			Directions
Select one or multiple preferred				orized and are or Medicare Pa		ropriate for your specific patient.
Cutaquig® 16.5% Cuvitru TM 20% Gammagard® liquid 10% Gammaked TM 10% Gamunex®-C 10%	Hizentra® 20% prefilled syringe Hizentra® 20% vial Xembify® 20% Any brand Other	Once wee	mg pe grams ekly Ev quency			Infuse total dose of immune globulin subcutaneously in 1 to multiple sites via infusion pump as tolerated. Infusion rates per manufacturer recommendation as tolerated.
HyQvia™ (Immune Globulin 10% (Human) with Recomb Hyaluronidase 160 units per Total IG grams: Infuse total grams per the ramp up so total grams: every 4 weeks. every 3 weeks. Where clinically appropriate, round nearest vial size.	oinant Human er mL)* hedule, then infuse	Ramp up scl Treatment into 1st infusion 2nd infusion 3rd infusion 4th infusion	1st week 2nd week 4th week	4 weeks grams x 0.25 grams x 0.50 grams x 0.75 give total dose	3 weeks grams x 0.33 grams x 0.67 give total dose	Infuse Hyaluronidase subcutaneously in 1–2 sites at 1–2mL per minute per site as tolerated. For each full or partial vial of immune globulin infused, administer the entire contents of the Hyaluronidase vial. Infuse total dose of immune globulin subcutaneously in 1–2 sites via infusion pump as tolerated. Infusion rates per manufacturer recommendation. Flush infusion line with 0.9% Normal Saline 10mL as needed for full dose administration.

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

Pharmacist selection allowed

rrescription & Enrollment Form:	Subcutaneous infinitine globuliii (SCIC	1)		rax completed form to 650.606.646
Patient's first name	Last name _		Middle initial	Date of birth
Prescriber's first name	La	st name		Phone
4 Prescribing	Information			
 Epinephrine 0.3mg auto-ir anaphylactic reaction time 	: (Accredo will provide an epinephrin njector 2-pk for patients weighing gro s one dose injector 2-pk for patients weighing le	eater than or equal	to 30kg. Administer intram	,
	y mouth for mild allergic reactions a	nd 50mg for moder	ate to severe	
Supplies: (please strike throug Dispense needles, syringes, a	gh if not required) ncillary supplies and home medical	equipment necessa	ry to administer medication	1.
otherwise.	month supply. Refill x 1 year unless		Dispense 90-day supply.	Refill x 1 year unless noted
Skilled nursing visits to educa	ease strike through if not required) te patient on subcutaneous access, o therapy; patient discharged from r			erapy and disease state and to asses:
f shipped to physician's office of	r infusion clinic, physician accepts on	behalf of patient for	administration in office or in	fusion clinic.
Prescriber's signature require	d (sign below) (Physician attests	this is his/her lega	l signature. NO STAMPS)	
GN				
Date Date	Dispense as written	Date	Substitu	tion 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.





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.

Refe	Referral form¹ (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			
Clini	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	D81.0 - Severe combined immunodeficiency	D82.0 - Wiskott-Aldr
D80 - Immunodeficiency with predominantly antibody defects	(SCID) with reticular dysgenesis	D82.1 - Di George's
D80.0 – Hereditary hypogammaglobulinemia	D81.1 - Severe combined immunodeficiency (SCID) with low T- and B-cell numbers	D82.4 – Hyperimmun
D80.2 - Selective deficiency of immunoglobulin A (IgA)	D81.2 – Severe combined immunodeficiency (SCID) with low or normal B-cell numbers	D83 – Common varia
D80.3 - Selective deficiency of immunoglobulin G (IgG) subclasses	D81.5 - Purine nucleoside phosphorylase (PNP) deficiency	D83.0 - CVID with pr of B-cell nur
D80.4 - Selective deficiency of immunoglobulin M (IgM)	D81.6 - Major histocompatibility complex class I deficiency	D83.1 – CVID with properties of the properties o
D80.5 – Immunodeficiency with increased immunoglobulin M (IgM)	D81.7 - Major histocompatibility	D83.2 - CVID with au
D80.6 – Antibody deficiency with near-normal immunoglobulins or	complex class II deficiency D81.89 – Other combined immunodeficiencies	D83.8 - Other CVIDs
with hyperimmunoglobulinemia D80.7 – Transient hypogammaglobulinemia	D81.9 - Combined immunodeficiency, unspecified	D83.9 - CVID, unspe
of infancy D81 – Combined immunodeficiencies	D82 – Immunodeficiency associated with other major defects	G11.3 - Cerebellar a

D82.0 - Wiskott-Aldrich syndrome

D82.1 - Di George's syndrome

D82.4 - Hyperimmunoglobulin E (IgE) syndrome

D83 - 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

G11.3 - Cerebellar ataxia with defective DNA repair

To receive in-home administration for intravenous immune globulin (IVIG) for the treatment of PIDD, Medicare Part B patients must be enrolled in the IVIG Demonstration initiative. For further information visit: https://med.noridianmedicare.com/web/ivig

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.



Prior Authorization Checklist Neuromuscular Disorders¹

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.

Refe	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				
Clin	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				
	ing documentation: Electrophysiological motor-sensory nerve conductions Electromyography (EMG) Cerebrospinal fluid (CSF) Biopsy (muscle-nerve) - if necessary				

Add	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			

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 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, 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