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

Subcutaneous immune globulin (SCIG)

accredo®

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 _____

Parent/guardian (if applicable) _____ Phone _____

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

Please attach copies of front and back of patient's insurance cards.

Insurance Company _____ Phone _____

Identification # _____ Policy/group # _____

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 _____ 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 _____

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 or multiple preferred SCIG 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 ☐ Cutaquig® 16.5% ☐ Cuvitru™ 20% ☐ Gammagard® liquid 10% ☐ Gammaked™ 10% ☐ Gamunex®-C 10% ☐ Hizentra® 20% prefilled syringe ☐ Hizentra® 20% vial ☐ Xembify® 20% ☐ Any brand ☐ Other _____	Infuse _____ gram(s) OR _____ mg per kg OR OR _____ grams per kg subcutaneously ☐ Once weekly ☐ Every 2 weeks ☐ Other frequency _____ (where clinically appropriate, round to the nearest vial size)	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 Infusion 10% (Human) with Recombinant Human Hyaluronidase 160 units per mL)* Total IG grams: _____ Infuse total grams per the ramp up schedule, then infuse total grams: ☐ **every 4 weeks**. ☐ **every 3 weeks**. Where clinically appropriate, round each dose to the nearest vial size.	Ramp up schedule: Treatment interval | 4 weeks | 3 weeks 1st infusion | 1st week | grams x 0.25 | grams x 0.33 2nd infusion | 2nd week | grams x 0.50 | grams x 0.67 3rd infusion | 4th week | grams x 0.75 | give total dose 4th infusion | 7th week | 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

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

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Adverse reaction medications: *(Accredo will provide an epinephrine auto injector with the first fill only)*

- 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

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

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

Accredo nursing services: *(please strike through if not required)*
Skilled nursing visits to educate patient on subcutaneous access, medication administration, use of supplies, therapy and disease state and to assess general status and response to therapy; patient discharged from nursing once teaching complete.

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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