POLARIS SPECIALTY RX

Immune Globulin – Auto Immune Disorder Prescription Order Form

Fax: 877.265.9119
Phone: 800.540.4700

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other: _____ Anticipated Start Date: _____

PATIENT INFORMATION

Last Name: _____
First Name: _____
SSN: _____ Date of Birth: _____
Gender: ☐ M ☐ F Height: _____ Weight: _____ ☐ lbs ☐ kg
Allergies: _____
Home #: _____ Alt #: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Guardian/Caregiver: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
☐ MD ☐ DO ☐ NP ☐ PA
Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____
License #: _____ NPI: _____ DEA#: _____
Phone: _____ Fax: _____
Contact Name: _____ Phone: _____
Collaborating Physician: _____

Please fax FRONT and BACK copy of ALL insurance cards (Prescription and Medical), most recent H&P, clinical assessment notes, and current medication list

PRIMARY DIAGNOSIS

☐ G61.0 Acute Infective Polyneuritis (Guillain-Barre Syndrome)
☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy
☐ G70.01 Myasthenia Gravis w/Exacerbation
☐ Other: _____

PRE-TREATMENT

☐ Tylenol 325mg PO 30 minutes prior to infusion
☐ Benadryl 25mg PO 30 minutes prior to infusion
☐ Solumedrol 125mg IVP 30 minutes prior to infusion
☐ Hydration: Normal Saline 0.9% to be infused with daily IVIG ☐ 500ml ☐ 1000ml
☐ Zofran 4mg IVP 30 minutes prior to infusion
☐ Other: _____

ADMINISTER IVIG

Product: ☐ Formulation: _____ or ☐ Pharmacist to determine dose
(please select one and provide complete information)

☐ 2g/kg over ____ days, repeat course every ____ week(s) for ____ cycle(s)
☐ _____ mg/kg or _____ g every ____ week(s) for ____ cycle(s)
☐ Other regimen: _____

Is this the first dose? ☐ Yes ☐ No If no, date first dose given: _____
Next dose given: _____
Infusion rate: Infuse per Polaris Home Infusion of Immune Globulin policy
Infusion reaction: Per Polaris Patient Infusion Reaction policy

Access: ☐ Peripheral ☐ PICC ☐ Port ☐ Other: _____
Flushing: Polaris Pharmacy Guideline (heparin 10-100u/ml, 0.9% NaCL and/or D5W flushes PRN to establish and maintain IV access)

Anaphylaxis Kit PRN for infusion reaction will contain the following (1 each):

- ✓ Diphenhydramine 25mg cap
- ✓ Diphenhydramine 50mg/ml
- ✓ Solumedrol 125mg vial
- ✓ 0.9% NaCL 500ml bag
- ✓ Zofran 4mg vial IVP
- ✓ Auvi-Q or EpiPen*

*Inject IM/SQ into outer thigh PRN allergic reaction, including anaphylaxis

- ✓ Auvi-Q 0.3mg for patients ≥ 30kg
- ✓ Auvi-Q 0.15mg for patients 15-30kg
- ✓ Auvi-q 0.1mg for patients 7.5-15kg

If Auvi-Q not covered, use EpiPen:

- ✓ EpiPen 0.3mg for patients ≥ 30kg or EpiPen Jr 0.15mg for patients < 30kg

- Lab Orders: _____

- Skilled Nursing visits needed to establish venous access, administer medication and assess general status and response to therapy.
- Infusion pump and supplies are necessary to administer therapy

PRESCRIBER SIGNATURE

(Prescriber, please and date below)

No stamps. Signature and date must be completed in prescriber's handwriting.
NY prescriptions must be submitted via e-script.

Prescriber Signature – Substitution Permissible | Date | Prescriber Signature – Dispense as Written | Date

I authorize Polaris Specialty Pharmacy to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including submission of any necessary forms to such health plans.