POLARIS SPECIALTY RX

Fax: 877.265.9119
Phone: 800.540.4700

Immune Globulin – Primary Immune Deficiency Prescription Order Form

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

☐ D83.9 Common Variable Immunodeficiency (CVID)
☐ D81.9 Combined Immunity Deficiency & SCID
☐ D80.0 Hereditary Hypogammaglobulinemia
☐ D80.1 Nonfamilial Hypogammaglobulinemia
☐ D80.5 Immunodeficiency with Increased IgM
☐ D83.1 CVID w/predominant Immunoregulatory T-Cell D/O
☐ D80.2 Selective IgA Immunodeficiency
☐ D80.4 Selective IgM Immunodeficiency
☐ D82.0 Wiskott-Aldrich Syndrome
☐ D80.3 Selective Deficiency of IgG Subclasses
☐ Other: ____

PRE-TREATMENT

☐ Tylenol 325mg PO 30 minutes prior to infusion
☐ Benadryl 25mg PO 30 minutes prior to infusion
☐ Emla Cream apply to injection site PRN ☐ None
☐ Other: ___________________________

PRESCRIPTION INFORMATION

Medication Orders ☐ IVIG ☐ Subcutaneous Brand ____________________________

Dose: _______ gms/day for _______ days, every _______ days, every _______ month(s)

OR _______ gms/kg/day for _______ days, every _______ days, every _______ month(s)

Refills: _________________________

Is this the first dose? ☐ Yes ☐ No If no, date first dose given: ____________

Next dose given: ____________

Infusion rate if IVIG: Infuse per Polaris Home Infusion of Immune Globulin policy
Infusion rate if SUB-Q: As directed by manufacturer recommendations as tolerated by patient
Infusion reaction: Per Polaris Patient Infusion Reaction policy

Access: ☐ Peripheral ☐ PICC ☐ Port ☐ Other: ________________________

Flushing, if applicable: 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 sign 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.