RE SPECIALTY PHARMACY

FAX

To: River's Edge Pharmacy **Fax:** 877.834.1231 **E-Fax:** faxes@repharmacy.com **Phone:** 866.413.3156	**From**(Office Contact)**:** _____ **Fax:**_____ **Phone:**_____

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

FOR TIMELY PROCESSING OF MY PATIENT'S PRESCRIPTIONS, THE FOLLOWING DETAIL IS INCLUDED WITHIN THIS FAX:

☐ **Rx** (prescription signed and dated by prescriber)

☐ **Insurance Information** (include copy of insurance card if available)

☐ **Patient Demographics** (include patient's height and weight)

☐ **Recent Clinical Notes** (history and physical, most recent progress notes)

☐ **Diagnosis Documentation** (i.e. labs, diagnostic studies, biopsy, etc.)

ADDITIONAL INCLUDED DOCUMENTATION (BY DISEASE STATE):

☐ **Primary Immunodeficiency** (labs/Ig levels, tried and failed medications, pneumococcal antibody titers)

☐ **CIDP/GBS/MMN** (EMG, nerve conduction study, lumbar puncture, labs, tried and failed medications)

☐ **MG** (serologic testing, tried and failed medications, any notes that describe exacerbations or MG crisis)

☐ **Pemphigus/Pemphigoid** (labs, skin biopsy, tried and failed medications)
Polymyositis/Dermatomyositis (labs, skin/muscle biopsy, tried and failed medications)

Comments:

AUTOIMMUNE PRESCRIPTION FORM

Phone: 866.413.3156 Fax: 877.834.1231/faxes@repharmacy.com

RE SPECIALTY PHARMACY

Patient Information

Name:			Parent/Guardian (if applicable):	
DOB:	Height:	Weight:	Phone:	Email:
Address:			City, State, Zip:	
☐ Male ☐ Female	First Dose of IVIG: ☐ YES ☐ NO		Prior IG Brands Used:	
Specific Adverse Reaction w/ Prior Brands:				
Allergies:				

Diagnosis

- ☐ Autoimmune Encephalopathy G04.81
- ☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) G61.81
- ☐ Dermatopolymyositis M33.90
- ☐ Guillain- Barre Syndrome (GBS) G61.0
- ☐ Inflammatory Neuropathies G61.89
- ☐ Multifocal Motor Neuropathy G61.82
- ☐ Myasthenia Gravis (MG) G70.0
- ☐ Myasthenia Gravis w/Acute Exacerbation G70.01
- ☐ Pemphigoid L12.0
- ☐ Pemphigus L10.9
- ☐ Polymyositis M33.20
- ☐ Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS) D89.89
- ☐ Stiff Person Syndrome G25.82
- ☐ Other: _____

Prescription Information

Product: **Pharmacist to Determine** **Physician Branded** _____

☐ **Intravenous Immunoglobulin**
Recommended dose 1gm/kg – 2gm/kg **Infuse:**_____ gm/kg
Infuse:
☐ IV daily over _____ days;
repeat every _____ weeks; _____ months
☐ Other: _____

☐ **Subcutaneous Immunoglobulin**
Pharmacy to determine # of sites unless alt # of sites indicated here:_____
Infuse:
☐ _____ times; _____weeks; _____ months
☐ Other:_____

Infusion Rate: ***Please select one and provide complete information***
☐ Pharmacist to determine per manufacturer recommendations
☐ Start at _____ mL/hour then increase by _____ mL/hour every_____ minutes to maximum rate _____ mL/hour

IV Access: ☐ Peripheral ☐ PICC ☐ Port ☐ Other: _____

IV Maintenance (Flushing): ***Dispense quantity sufficient***
☐ Sodium chloride 0.9% 10mL prefilled syringe: flush IV access device with sodium chloride 1-10mL to maintain line patency
☐ Heparin 100 units/mL 5mL prefilled syringe: flush with 100 units/mL 3-5 mL as needed to maintain line patency

Pretreatment: ***Dispense quantity sufficient***
☐ Acetaminophen 325mg tablet: 1-2 tablets by mouth 15-30 minutes before each infusion
☐ Diphenhydramine 25mg capsule: 1-2 capsules by mouth 15-30 minutes before each infusion
☐ Other: _____

Ancillary Supplies: *Dispense ancillary supplies and equipment needed to provide home infusion therapy* **Refills:** _____

Labs: ***Labs will not be drawn on weekends/holidays. Not for STAT labs.***
Labs to be drawn: _____ Frequency of labs: _____

Adverse/Anaphylactic Reactions: ***Anaphylaxis kit to be used in the event of anaphylactic reaction and includes the below components:***
Diphenhydramine 25mg capsule (qty 2), Diphenhydramine 50mg/mL 1mL vial (qty 1), Epinephrine injection auto-injector 0.3mg (>30kg pt) or 0.15mg (<30kg pt) (qty 1 two-pack), Sodium chloride 0.9% 500mL bag (qty 1), and Sodium chloride 0.9% 10mL prefilled syringe (qty 4)

Nursing Orders: ***Nurse to administer IVIG and ancillary medications per orders. Skilled nursing visits for education of SCIG administration (not applicable if independent with therapy)***

Physician Information

Physician:		**Office Contact:**	
Address:		City, State, Zip:	
Phone:	Fax:	License:	NPI:

Number of Drugs Prescribed: _____ **(Prescription is void if number of drugs are not indicated. Regulation 16 CCR 1717.3)**

Prescriber's Signature:	**Date:**

IMMUNE DEFICIENCY PRESCRIPTION FORM

Phone: 866.413.3156 Fax: 877.834.1231/ faxes@repharmacy.com

RE SPECIALTY PHARMACY

Patient Information

Name:			Parent/Guardian (if applicable):	
DOB:	Height:	Weight:	Phone:	Email:
Address:			City, State, Zip:	
Male Female	First Dose of IVIG: ☐ YES ☐ NO		Prior IG Brands Used:	
Specific Adverse Reaction w/ Prior Brands:				
Allergies:				

Diagnosis

- ☐ Combined Immunodeficiency, Unspecified D81.9
- ☐ Common Variable Immunodeficiency, Unspecified D83.9
- ☐ CVID w/Predominant Immunoregulatory T-Cell Disorders D83.1
- ☐ Hereditary Hypogammaglobulinemia D80.0
- ☐ Immunodeficiency w/Increased IgM D80.5
- ☐ Nonfamilial Hypogammaglobulinemia D80.1
- ☐ Other Combined Immunodeficiencies D81.89
- ☐ Other:_____

Prescription Information

Product: **Pharmacist to Determine** **Physician Branded:**_____

☐ **Intravenous Immunoglobulin**

Recommended dose 0.4 – 0.8 gm/kg infuse:_____gm/kg

Infuse:

☐ IV daily over _____ days;

repeat every _____ weeks; _____ months

☐ Other: _____

☐ **Subcutaneous Immunoglobulin**

Pharmacy to determine # of sites unless alt # of sites indicated here:_____

Infuse:

☐ _____ grams subcutaneously ;

_____ times; _____weeks; _____ months

☐ Other:_____

Infusion Rate: ***Please select one and provide complete information***

☐ Pharmacist to determine per manufacturer recommendations

☐ Start at _____ mL/hour then increase by _____ mL/hour every_____ minutes to maximum rate _____ mL/hour

IV Access: ☐ Peripheral ☐ PICC ☐ Port ☐ Other: _____

IV Maintenance (Flushing): ***Dispense quantity sufficient***

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Prescriber's Signature:	**Date:**