BARNES HEALTHCARE SERVICES

IVIG Order Form

Please fax all pages of completed form to our Intake team at 866.301.9063
Contact our Intake team 800.422.5059 ext.1480

1 Patient Information — Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ **Last name** _____ **MI** _____

Preferred patient first name _____ **Preferred patient last name** _____

Sex at birth: ☐ Male ☐ Female **Gender identity** _____ **Pronouns** _____

Last 4 of SSN _____ **Date of birth** ____/____/____

Street address _____ **Apt #** _____

City _____ **State** _____ **Zip** _____

Home phone _____ **Cell phone** _____ **Email address** _____

Parent/guardian (if applicable) _____

Home phone _____ **Cell phone** _____ **Email address** _____

Alternate caregiver/contact _____

Home phone _____ **Cell phone** _____ **Email address** _____

☐ OK to leave message with alternate caregiver/contact

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

Provider will read the following statement to patient: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Barnes Healthcare Services about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

2 Prescriber Information — All fields must be completed to expedite prescription fulfillment.

Date _____ **Time** _____ **Date medication is needed** ____/____/____

Office/clinic/institution name _____

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:

Infusion site _____ **Clinic/hospital affiliation** _____

Site street address _____ **Suite #** _____

City _____ **State** _____ **Zip** _____

Infusion site contact _____ **Phone** _____ **Fax** _____

Email _____

Note: Check the appropriate shipment options in Section 4: Prescribing Information.

3 Clinical Information

Primary ICD-10 code (REQUIRED):

Immunology:

☐ Congenital Hypogam: D80.0 ☐ CVID (unspecified): D83.9 ☐ SCID (unspecified): D81.9

Neurology:

☐ CIDP: G61.81 ☐ MMN: G61.82 ☐ MS (rel/remit): G35

☐ GBS: G61.0 ☐ MG: G70.00

Rheumatology:

☐ Polymyositis: M33.20 ☐ Dermatomyositis: M33.90

☐ Other [code(s) and description]: _____

☐ NKDA **List of all known drug allergies:** _____

4 Prescribing Information

Authorize "Pharmacist to select brand" or list preferred brand below AND sign the "SUBSTITUTION ALLOWED" line to authorize "Pharmacist to select brand" based on information available, including clinical information, insurance requirements and brand availability. By signing "SUBSTITUTION ALLOWED" you acknowledge that all brands are clinically appropriate for the patient. Accredo will communicate to you the brand selected.
PRESCRIBER MUST SELECT A BRAND FOR MEDICARE PART B PATIENTS

Route: ☐ Subcutaneous ☐ Intravenous **Brand:** ☐ Pharmacist to select brand ☐ Prescriber's preferred brand listed below (required for Medicare B): _____	Infuse _____ gram(s) *OR* _____ mg per kg ☐ Once weekly ☐ Every 2 weeks ☐ Every 4 weeks ☐ Other frequency_____ **Where clinically appropriate, round to the nearest vial**	**If subcutaneous:** Infuse total dose of immune globulin subcutaneously in 1 to multiple subcutaneous sites via infusion pump as tolerated. Infusion rates per manufacturer recommendation as tolerated.

If Intravenous: Titrate initial and maintenance infusion rates per manufacturer's product labeling. Vascular access: ☐ Peripheral ☐ Central ☐ Port Infusion method: ☐ Gravity ☐ Pump	**Hydration for Intravenous:** ☐ Infuse 500mL of 0.9% Normal Saline intravenously prior to infusion over 30 minutes ☐ Infuse 500mL of D5W intravenously given concurrent with IVIG at same rate as IG ☐ Other _____

CHECK ONE

Premedications to be given 30 minutes prior to infusion (strike through if not required):

Diphenhydramine 25mg by mouth for mild infusion reaction, may increase to 50mg for history of moderate to severe infusion reaction (contraindicated in patients with myasthenia gravis)

For pediatric patients the following weight and aged based dosing range will be used for all Diphenhydramine prescribed:

≤9kg and/or <2 years old: 1mg/kg up to max of 6.25mg, 2-5 years old and >9kg: 6.25mg to 12.5mg, 6-12 years old: 12.5mg to 25mg

Acetaminophen 650mg by mouth (For pediatric patients weighing less than 60kg: Acetaminophen 10-15mg/kg by mouth for all Acetaminophen prescribed)

Other _____

Medications to be used as needed (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

Adverse event medications (Keep on hand at all times; Accredo will provide an epinephrine auto injector with the first subcutaneous fill only):

Epinephrine 0.3mg for patients weighing ≥30kg or 0.15mg for patients weighing <30kg auto-injector 2-pk. Administer intramuscularly as needed for severe anaphylactic reaction times one dose

Diphenhydramine 25mg by mouth for mild allergic reaction and 50mg for moderate to severe

BARNES HEALTHCARE SERVICES

IVIG Order Form

Flushing for Intravenous: 0.9% Normal Saline 3mL intravenous (peripheral line) or 10mL intravenous (central line/port) before and after infusion, or as needed for line patency Heparin 10 units per mL 3mL intravenous (peripheral line) as needed for final flush Heparin 100 units per mL 5mL intravenous (central line/port) as needed for final flush
Supplies: Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication **(A4221, A4221, S9338, E0779)**
Quantity/Refills: Dispense 1 month supply. Refill x 1 year unless noted otherwise Other:_____
Skilled Nursing: IVIG- Visit as needed to establish venous access, administer medication and assess general status and response to therapy. SubQ IG- 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 to be discharged from nursing once teaching iscomplete.

Ongoing lab orders: For Immune deficiency, IGG trough level and CMP every 6 months. For Neurological, CMP every 6 months.

If "Pharmacist to select brand" option chosen above, sign the "SUBSTITUTION ALLOWED" line below.

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**

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.

5a. Prior Authorization Checklist: Primary Immune Deficiency Disease (PIDD)

Providing Barnes Healthcare 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.

Referral form[1] (not required for electronic prescriptions)	
	Completed Immunoglobulin (Ig) referral form
	Copies of the front and back of **all** medical insurance and prescription benefits cards
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
D80 – Immunodeficiency with predominantly antibody defects
D80.0 – Hereditary hypogammaglobulinemia
D80.2 – Selective deficiency of immunoglobulin A (IgA)
D80.3 – Selective deficiency of immunoglobulin G (IgG) subclasses
D80.4 – Selective deficiency of immunoglobulin M (IgM)
D80.5 – Immunodeficiency with increased immunoglobulin M (IgM)
D80.6 – Antibody deficiency with near-normal immunoglobulins or with hyperimmunoglobulinemia
D80.7 – Transient hypogammaglobulinemia of infancy
D81 – Combined immunodeficiencies
D81.0 – Severe combined immunodeficiency (SCID) with reticular dysgenesis
D81.1 – Severe combined immunodeficiency (SCID) with low T- and B-cell numbers
D81.2 – Severe combined immunodeficiency (SCID) with low or normal B-cell numbers
D81.5 – Purine nucleoside phosphorylase (PNP) deficiency
D81.6 – Major histocompatibility complex class I deficiency
D81.7 – Major histocompatibility complex class II deficiency
D81.89 – Other combined immunodeficiencies
D81.9 – Combined immunodeficiency, unspecified
D82 – Immunodeficiency associated with other major defects
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

BARNES HEALTHCARE SERVICES

IVIG Order Form

5b. Prior Authorization Checklist: Neuromuscular Disorders

Providing Barnes Healthcare 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.

Referral Form (not required for electronic prescriptions)	
	Completed Immunoglobulin (Ig) referral form
	Copies of the front and back of all medical insurance and prescription benefits cards
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
Testing documentation: ☐ Electrophysiological motor-sensory nerve conductions ☐ Electromyography (EMG) ☐ Cerebrospinal fluid (CSF) ☐ Biopsy (muscle-nerve) - if necessary	
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

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 polymyositis, and refractory dermatomyositis All home neuro IVIG is covered under the par D benefit

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