Immune Globulin Medication Request

Aetna Specialty Pharmacy®
503 Sunport Lane
Orlando, FL 32809

Customer Service: 1-866-782-ASRX (1-866-782-2779) **Fax Order Submission: 1-866-FAX-ASRX (1-866-329-2779)**

For your convenience, this medication request may be submitted via E-PRESCRIBE to Aetna Specialty Pharmacy

Aetna Specialty Pharmacy will verify benefits and contact members to confirm delivery before medication is shipped.

Today's Date: **Date Needed:**

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
Weight:	Height:	Allergies:	

B. INSURANCE INFORMATION

Carrier Name: _____
Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, Carrier Name: _____
Member ID#: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, ID #: **Medicaid**: ☐ Yes ☐ No If yes, ID #:

C. PHYSICIAN INFORMATION

First Name:	Last Name: *(Check one)*: ☐M.D. ☐D.O. ☐N.P. ☐P.A.		
Address:	City:	State:	ZIP:
Phone: / Fax:	DEA #: / NPI #:	Office Contact:	

D. DIAGNOSIS

Primary ICD Code: Other ICD Code:

E. PRESCRIPTION

Please refer to the insurance carrier's participating provider precertification list to verify precertification requirements.

Medication	Directions	Quantity	Refills
☐ BIVIGAM ☐ GAMMAPLEX ☐ CARIMUNE NF ☐ GAMUNEX-C ☐ FLEBOGAMMA ☐ HIZENTRA ☐ GAMASTAN S/D ☐ HYQVIA ☐ GAMMAGARD LIQUID ☐ OCTAGAM ☐ GAMMAGARD S/D ☐ PRIVIGEN ☐ GAMMAKED ☐ VIVAGLOBIN	1) ***ROUTE*** ☐ SUB-Q ☐ I.V. ☐ I.M 2) ***DOSE:*** (Wt: kg ***OR*** lbs) Grams ***OR*** mg/kg 3) ***DIRECTIONS:*** ☐ Infuse SUB-Q every _____ week(s) into _____ injection sites over _____ hour(s) ☐ Infuse I.V. every _____ week(s) over _____ hour(s) ☐ Inject I.M. every _____ week(s) into _____ sites. ☐ Other: _____	☐ 1 month ☐ Other:	
DILUENTS AND FLUSHES ☐ NS FLUSH ☐ D5W 50ML FOR FLUSH ☐ HEPARIN 10U/ML FLUSH ☐ HEPARIN 100U/ML FLUSH ☐ NS I.V. BAG ☐ 100ML ☐ 250ML ☐ 500ML ☐ Other:	☐ _____Before and after infusion ☐ Other: _____ ☐ _____Before and after infusion ☐ Other: _____ ☐ _____After infusion ☐ Other: _____ ☐ _____After infusion ☐ Other: _____ ☐ _____As directed ☐ Other: _____ ☐ _____As directed ☐ Other: _____ ☐ _____As directed ☐ Other: _____ ☐ _____As directed ☐ Other: _____	☐ 1 month ☐ Other:	
PRE-MEDICATIONS: ☐ SOLU-CORTEF ☐ SOLU-MEDROL ☐ BENADRYL ☐ Other:	☐ _____As directed (Pre-med) ☐ Other: _____ ☐ _____As directed (Pre-med) ☐ Other: _____ ☐ _____As directed (Pre-med) ☐ Other: _____ ☐ _____As directed ☐ Other: _____	☐ 1 month ☐ Other:	
ALLERGY/ANAPHYLAXIS MEDICATIONS: ☐ BENADRYL ☐ EPINEPHRINE (1:1000) ☐ EPIPEN ☐ JR 0.15mg ☐ 0.3mg ☐ Other:	☐ _____PRN allergic reaction ☐ Other: _____ ☐ _____PRN anaphylaxis ☐ Other: _____ ☐ _____*PRN anaphylaxis* ☐ *Other:* _____ ☐ _____As directed ☐ Other: _____	☐ 1 month ☐ Other:	
☐ EMLA CREAM			
☐ Other:			

Ship to: ☐ Physician's Office ☐ Patient ☐ Other address:

*Interchange is mandated unless practitioner handwrites the words **"MEDICALLY NECESSARY"** for each medication.*

Prescriber's Signature **(Required by Law):**

Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through specialty pharmacy prescription fulfillment. This pharmacy is a for-profit entity.