



Patient Referral/ Medication Request IVIg Therapy

Aetna Specialty Pharmacy®
503 Sunport Lane
Orlando, FL 32809
Phone: 1-866-782-2779 (1-866-782-ASRX)
FAX: 1-866-329-2779 (1-866-FAX-ASRX)
www.AetnaSpecialtyPharmacy.com

Today's Date: _____

Anticipated Start Date: _____

PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
Ship Meds to: <input type="checkbox"/> Patient Home <input type="checkbox"/> Infusion Center <input type="checkbox"/> Doctor's		Email Address:	

Please note: All supplies, including syringes and needles, will be dispensed as needed.

INSURANCE INFORMATION

Primary Insurance:		Pharmacy Benefit Manager (PBM):	
Policy #:	Group #:	Insured:	Phone:
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide #:	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide #:

Secondary Insurance:

Policy #:	Group #:	Insured:	Phone:
-----------	----------	----------	--------

PHYSICIAN INFORMATION

First Name:	Last Name:	M.D./D.O.	
Address:	City:	State:	ZIP:
Phone:	Fax:	St Lic. #:	NPI #:
Office Contact Name:		Email Address:	Phone:

DIAGNOSIS:

<input type="checkbox"/> Bone marrow transplant (V42.81)	<input type="checkbox"/> ITP (287.31)	<input type="checkbox"/> Plasma Cell leukemia (203.10)
<input type="checkbox"/> CIDP (357.81)	<input type="checkbox"/> Lymphoid Leukemia, Chronic (204.10)	<input type="checkbox"/> Polymyositis (710.4)
<input type="checkbox"/> Combined Immunity Deficiency (279.2)	<input type="checkbox"/> Multiple Myeloma (203.00)	<input type="checkbox"/> Prophylactic immunotherapy (V07.2)
<input type="checkbox"/> Congenital hypogammaglobulinemia (279.04)	<input type="checkbox"/> Multiple sclerosis (340)	<input type="checkbox"/> SLE (710.0)
<input type="checkbox"/> CVID (279.06)	<input type="checkbox"/> Myasthenia gravis (358.00)	<input type="checkbox"/> Stiff-man syndrome (333.91)
<input type="checkbox"/> Deficiency of humoral immunity (279.00)	<input type="checkbox"/> Other immunoproliferative neoplasms (203.80)	<input type="checkbox"/> Thombocytopenia, unspecified (287.5)
<input type="checkbox"/> Dermatomyositis (710.0)	<input type="checkbox"/> Other specified idiopathic & unspecified peripheral neuropathy (356.8-356.9)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> HIV (042)		

Are Nursing Services Needed? Yes No

VITAL INFORMATION

- Obtain baseline vital signs (T, P, R, BP) _____
- Obtain vital signs every 15 minutes for first hour, then every hour for remainder of infusion.
- Weight: _____ kg, Height: _____ Allergies: _____
- Will this be the first IV infusion? Yes No If No, what was the date of the patient's last infusion? _____
- Does the patient already have a line? Yes No If Yes, what is the line type? _____

TARGET CONCENTRATION AND SUGGESTED RATE OF INFUSION

For patients at risk for developing renal dysfunction, reduce the rate of infusion. Specify alternative rate of infusion or corresponding infusion rate below will be used as prescribed rate: _____

<input type="checkbox"/> Gamunex 10% <i>Suggested rate of infusion:</i> 1. 0.01ml/kg/min. x 30 minutes. If tolerated, 2. Gradually increase to 0.08ml/kg/min, 3. If side effects occur, reduce rate or interrupt infusion until symptoms subside. 4. Resume infusion at the rate which is comfortable to the patient.	<input type="checkbox"/> Octagam 5 % <i>Suggested rate of infusion:</i> 1. 30mg/kg/hr (0.01ml/kg/min.) x 30 minutes. If tolerated, 2. Increase to 60mg/kg/hr (0.02mg/kg/min.) x 30 minutes. If tolerated, 3. Increase to 120mg/kg/hr (0.04ml/kg/min.) as tolerated. 4. Max rate of 200mg/kg/hr (0.07ml/kg/min.) as tolerated.
<input type="checkbox"/> Gammagard Liquid 10% <i>Suggested rate of infusion:</i> 1. Start at 0.5Ls/kg/hr. 2. Gradually increase every 30 minutes to a rate of 5mLs/kg/hr, as tolerated.	<input type="checkbox"/> Privigen 10% <i>Suggested rate of infusion:</i> 1. 0.05mg/kg/min. (0.005ml/kg/min.) If well tolerated, 2. Gradually increase to a maximum rate of 8mg/kg/min. (0.08ml/kg/min.)
<input type="checkbox"/> Gammagard Powder* <i>Suggested rate of infusion:</i> For 5% solution 1. Start at 0.5ml/kg/hr. 2. Gradually increase to a maximum rate of 4ml/kg/hr, as tolerated. For 10% solution 1. Start at 0.5ml/kg/hr. 2. Gradually increase to a maximum rate of 8ml/kg/hr, as tolerated.	<input type="checkbox"/> Flebogamma 5% <i>Suggested rate of infusion:</i> 1. 0.01ml/kg/min. x 30 minutes. If well tolerated, 2. Gradually increase to a maximum rate of 0.10ml/kg/min. (5mg/kg/min.)

**Gammagard SD IgA less than 1 ug/ml in a 5% solution must be approved by Baxter at request of MD.*

VIVAGLOBIN: PLEASE REFER TO VIVAGLOBIN PRESCRIPTION REFERRAL FORM AT WWW.VIVAGLOBIN.COM OR CALL 1-877-848-2456 (1-877-VIVAGLOBIN).

HIZENTRA: PLEASE REFER TO HIZENTRA PRESCRIPTION REFERRAL FORM AT WWW.HIZENTRA.COM OR CALL 1-866-720-4373.

Patient's Name: _____ DOB: _____

TARGET CONCENTRATION AND SUGGESTED RATE OF INFUSION (continued)

Gammagard S/D Powder-final concentration 5% or 10%:			
Target Concentration	2.5g vial	5g vial	10g vial
5%	50ml	96ml	192ml
10%	25ml	48ml	96ml

PRESCRIPTION

- Octagam 5 %
- Gamunex 10%
- Gammagard Liquid 10%
- Gammagard S/D Powder - circle final concentration: 5% or 10%
- Flebogamma 5%
- Privigen 10%
- Other: _____

Dose: _____ Grams/kg= _____ Grams (Range: 0.2-2 Grams/kg)

Infuse intravenously over _____ hours, as tolerated by patient

- Repeat dose daily x _____ consecutive days total. Repeat dose monthly x _____ months.
- Repeat dose weekly x _____ weeks total.
- Repeat dose monthly x _____ months total.
- Other: _____.
- Patient is at risk of developing renal dysfunction. If so, the rate of infusion must be reduced to an alternate rate.

PRE-MEDICATIONS: To be administered 30 minutes prior to infusion (per infusion). Refills will be same as number prescribed for IVIG.

- Hydration prior to infusion: _____.
- Hydrocortisone 100mg/2ml vial (2mg/kg): _____ mg slow IVP. QTY: _____.
- Other: _____.

DILUENTS/FLUSHES: Per infusion. Refills will be the same as number prescribed for IVIG.

- Saline Flush (PIV 3-5ml; CIV 5-10ml), per nursing agency protocol. QTY: _____.
- Heparin Flush 10u/ml - PIV flush with 3-5ml, nursing agency protocol. QTY: _____.
- Heparin Flush 100u/ml - CIV flush with 3-5ml, per nursing agency protocol. QTY: _____.
- D5W 50ml for flush for Gamunex, Gammagard. QTY: _____.
- Other: _____ QTY: _____.

PROCEDURE FOR ANAPHYLAXIS and MEDICATIONS TO HAVE ON HAND:

1. Stop infusion.
2. Call the prescribing physician and 911 immediately.
3. Administer the following:
 - Benadryl 25-50mg IVP every four hours prn. (Rate not to exceed 25mg/minute.) QTY: _____.
 - Epinephrine (1:1000) 0.4mg sub-q prn anaphylaxis. May repeat q20 minutes x 2. QTY: _____.
 - Other: _____ QTY: _____.

POSSIBLE SYMPTOMS (RN TO MONITOR):
Discontinue use and notify the prescribing physician if patient demonstrates:

- Malaise, chest tightness, a feeling of faintness, dyspnea, fever/chills, chest/back or hip pain, nausea/vomiting, mild erythema, hypotension/hypertension, headache, fatigue, leg cramps, lightheadedness, urticaria, or flushing.
- AMS (aseptic meningitis syndrome) – **STOP THE INFUSION AND NOTIFY THE PRESCRIBING PHYSICIAN IMMEDIATELY.**
- Decreased urine output, sudden weight gain, fluid retention, and shortness of breath. – **Instruct patient to report such symptoms.**

Nursing agency to draw labs: _____
Specify labs to be drawn and frequency: _____

Prescriber's Signature Required by Law: _____ Date: _____

**Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space.
Incomplete information may result in therapy delay. Please complete all fields.**