Phone: 1-888-792-1552
Fax: 1-888-216-2510

To ePrescribe send prescription to:
Giant Eagle Pharmacy
20160 Center Ridge Road, Suite 201
Rocky River, OH 44116

IVIG ENROLLMENT FORM

Today's Date: ____________________

Ship to: ☐ Patient ☐ Physician ☐ Store for Patient Pick-up **Date Shipment Needed:**______________ **Rx:** ☐ New ☐ Refill **RN Instruction Needed:** ☐ Yes ☐ No

All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Date: ______________________________ ☐ Male ☐ Female DOB:______________
Patient's First Name: ___________________________ Patient's Last Name: ________________________________
Address: ____ City: _______________________ State: ______ ZIP: __________
Best Phone Number: ________________________________ Alternate Phone Number: ______________________________
Height:_____________________ Weight: _________________ ☐ kgs. or ☐ lbs. Recorded Date: __________________
Caregiver: ____ Caregiver Contact Number: ______________________________
Allergies: ____
Store Preference (address): ____
Discharge Date: ____
Emergency Contact Name: ________________________________ Emergency Contact Phone #: _______________________

Insurance Information: Please fax copy of insurance card (front + back)

Medical Assessment

DIAGNOSIS/ ICD-10 ____________

☐ Primary Immune Deficiency
☐ Multiple Sclerosis (MS)
☐ Kawasaki's Disease
☐ Myasthenia Gravis
☐ Idiopathic Thrombocytopenia Purpura (ITP)
☐ Chronic Lymphocytic Leukemia (CLL)
☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
☐ Dermatomyositis
☐ HIV
☐ Allogeneic BMT
☐ Polymyositis
☐ CIPD

Has the patient previously received IVIG? ☐ No ☐ Yes What brand? ______________________________
☐ Other: ____
Previous reaction to IVIG? ☐ No ☐ Yes Please explain: ____

IVIG (IV Immunoglobulin) Order: ______________________________________ (Will choose IVIG brand if not specified)

Prescription

IVIG Dose:__________grams/kg = __________ (round to nearest vial size) infuse intravenously
(Range: 0.2-2 grams/kg)
☐ Repeat does daily x ___________ consecutive days total, repeat dose: ☐ monthly x ____ months ☐ Other________________
☐ Repeat does weekly x ___________ weeks total ☐ Repeat does monthly x ___________ months total
☐ Others ____

SUGGESTED RATE OF INFUSION:
- 30-150 mL./hr. as tolerated by patient (increase rate gradually every 30 minutes by 20-30 mL./hr.)
- Other ____

Premedication (15 to 30 minutes before infusion):
Diphenhydramine: ☐ 50 mg IV ☐ 25 mg IV Acetaminophen: ☐ 1000 mg PO ☐ 500 mg PO
Other: ____

PROCEDURE FOR ANAPHYLAXIS
- Stop infusion and call MD & 911
- Diphenhydramine 25 - 50 mg IVP every 4 hours prn (Rate not to exceed 25 mg/min) QTY: 3 (50 mg)
- Epinephrine (1:1000) 0.4 mg SQ prn anaphylaxis, may repeat every 20 minutes x 2 QTY: 3 amp
- Other ____ QTY: _________

SUPPLIES FOR INFUSION (if necessary) QTY: QS
- NaCl 0.9%/D5W for flush: flush Line/Port with (3 - 5 mL. for PIV and 5 - 10 mL. for Central line/Port) per nursing agency protocol
(NaCl 0.9 % or D5W will be used based on IVIG)
- Heparin for flush (100 Units/mL.) (if RN keeps PIV or if needed for Central Line), flush with 3 - 5 mL. per nursing agency protocol.
- Sterile water for reconstitution of powder to make the requested concentration (for Carimune NF).
- Other ____

Prescriber Information

Date Prescription Needed: ____
Physician Name (please print): ______________________________ Contact Name: ___________________________
Phone #: ______________________________ Fax #:_______________________________ NPI #: _____________________
Office Address: ________________________________ City: ______________________________ State: _______ ZIP: __________
State License #: ____ DEA #: ____
In order for a brand name to be dispensed, the prescriber must hand write "brand medically necessary" or "brand necessary" in the space below.
____

I authorize this prescription and for Giant Eagle Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician Signature: ____ **Date:** ______________________