

IMMUNOGLOBULIN (IG) IV AND SUBQ ORDERS

P: 888-386-0886 | F: 586-263-3306

| Patient Name: | PATIENT INFO | ORMATION | Fax | completed for | m, insurance infor | mation and clir | ical documentation to 58 | 6-263-3306 |
|--|--|---|--|--|--|---|----------------------------------|-------------|
| MEDICAL INFORMATION ICD-10 descriptions: | Patient Name: | | | • | | | | |
| CD-10 Code (required): CD-10 descriptions: Diabetic: Diabe | Patient Status: ☐ N | lew to Therapy | ☐ Continuing The | rapy Date of la | ast infusion: | | | |
| Patient weight: | MEDICAL INF | ORMATIO | N | | | | | |
| Allergies: Brand previously used: THERAPY ORDER THERAPY ORDER TIV SQ Pharmacist to identify clinically appropriate brand/infusion rates. May substitute based on product availability. Loading Dose (as applicable) | ICD-10 Code (requir | red): | | ICD-10 des | criptions: | | | |
| THERAPY ORDER IV SQ Pharmacist to identify clinically appropriate brand/infusion rates. May substitute based on product availability. Loading Dose | | | | | | | |) |
| SQ Pharmacist to identify clinically appropriate brand/infusion rates. May substitute based on product availability. Loading Dose (as applicable) | | | | Brand previ | iously used: | | | |
| Loading Dose (as applicable) | THERAPY OR | DER | | | | | | |
| Loading Dose grams x | □IV □SQ Pharm | nacist to identif | y clinically approp | oriate brand/inf | usion rates. May su | bstitute based | on product availability. | |
| Maintenance mg/kg gm/kg gm/kg grams xday(s) OR divided overday(s) Qweeks x1 yea Other | Loading Dose (as applicable) | | ☐ gm/kg | □ xday(| (s) OR divided over | day(s) | ☐ Other: | |
| gm/kg | | | grams | | | | | veeks |
| If needed, round dose to nearest whole 5 gm vial for IV doses and nearest single-use vial size for subQ doses. Premedication orders: to be administered 15-30 minutes before infusion Acetaminophen 500mg PO | Maintenance Dose | | ☐ gm/kg | □ xday(| (s) OR divided over | day(s) | | |
| Acetaminophen 500mg PO | Infuse entire cor | ntents of Ig infusi | on bag/vial(s) per | | earest single-use vi | al size for subQ | doses. | |
| Acetaminophen 500mg PO | | | | | | | | |
| Anaphylactic Reaction Orders: • Epinephrine (based on patient weight) • >30kg (>66lbs): EpiPen® 0.3mg or compounded syringe IM or SQ; may repeat in 5-10 minutes x 1 • 15-30kg (33-66lbs): EpiPen® 0.15mg or compounded syringe IM or SQ; may repeat in 5-10 minutes x 1 • Diphenhydramine - Administer 25-50mg orally OR IV (adult), refer to provider orders or policy for pediatric dose • NS 500 mL IV bolus as needed for IVIg therapy (adult), refer to provider orders or policy for pediatric bolus Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN *FOR COMPASSUS USE ONLY Drug/Brand Selection: | Acetaminophen 500mg POSolu-Medrolmg IVP | | | □ Normal Saline 500mL IV □ Cetirizine 10mg PO □ Diphenhydramine 25mg PO □ Cetirizine 10mg PO | | | | |
| Epinephrine (based on patient weight) > 30 kg (>66lbs): EpiPen® 0.3mg or compounded syringe IM or SQ; may repeat in 5-10 minutes x 1 • 15-30 kg (33-66lbs): EpiPen® 0.15mg or compounded syringe IM or SQ; may repeat in 5-10 minutes x 1 • Diphenhydramine - Administer 25-50mg orally OR IV (adult), refer to provider orders or policy for pediatric dose • NS 500 mL IV bolus as needed for IVIg therapy (adult), refer to provider orders or policy for pediatric bolus Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN *FOR COMPASSUS USE ONLY Drug/Brand Selection: | Lab orders: | | | Lab frequenc | : y: ☐ Each infusion | □ Other: | | |
| Drug/Brand Selection: Date: | Epinephrine (base > 30kg (>66 15-30kg (33 Diphenhydramir NS 500 mL IV base > 150mm | sed on patient w 6lbs): EpiPen® O. 3-66lbs): EpiPen ne - Administer 2 olus as needed fo | 3mg or compound © 0.15mg or compous 25-50mg orally OR or IVIg therapy (ac | ounded syringe I R IV (adult), refer dult), refer to pro | M or SQ; may repeat to provider orders ovider orders or polic | t in 5-10 minute or policy for pedi y for pediatric b | atric dose olus | |
| Drug/Brand Selection: Date: | *FOR COMPA | SSIIS IISE (| ONIV | _ | _ | _ | | _ |
| PROVIDER INFORMATION By signing this form and utilizing our services, you are authorizing Compassus and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient. Provider Name: | | | | | | | Date: | |
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| By signing this form and utilizing our services, you are authorizing Compassus and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient. Provider Name: Signature: Date: Provider NPI: Phone: Fax: Contact Person: Opt out of Compassus selecting site of care (if checked, please list site of care) PREFERRED LOCATION | | | | | , | | | |
| Provider Name: Signature: Date: Date: Date: Provider NPI: Phone: Fax: Contact Person: Phone provider NPI: Phone: Fax: Contact Person: Provider NPI: | By signing this form and u | utilizing our services | , you are authorizing C | | | | and specialty pharmacy designate | ed agent in |
| Provider NPI: Phone: Fax:Contact Person: Opt out of Compassus selecting site of care (if checked, please list site of care) PREFERRED LOCATION | _ | | • | · | · | | Date: | |
| Opt out of Compassus selecting site of care (if checked, please list site of care) PREFERRED LOCATION | | | | | | | | |
| PREFERRED LOCATION | | | | | | | | |
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COMPREHENSIVE SUPPORT FOR IMMUNOGLOBULIN THERAPIES P: 888-386-0886 | F: 586-263-3306

REQUIRED DOCUMENTATION FOR INSURANCE APPROVAL

GENERAL REQUIREMENTS

- Patient demographics
- Insurance information
- All applicable diagnoses
- · History and physical
- Recent progress notes within 12 months

- Patient's height and weight
- Drug allergies
- Physician Orders
- Plus one of the following

COMMON VARIABLE IMMUNODEFICIENCY (CVID) / HYPOGAMMAGLOBULINEMIA / PARKINSON'S DISEASE (PD)

- Lab last showing Ig levels and subclasses Ig levels.
- Documentation of recurrent infections

- History of antibiotic usage showing failure to respond to antibiotics
- Documented inadequate response to pneumococcal vaccine or tetanus/diphtheria

CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP) / GUILLAIN-BARRÉ SYNDROME (GBS)

- Labs
- Nerve conduction study, electromyography (EMG)
- Nerve and/or muscle biopsy (if available)

- Nerve conduction velocity (NCV) test results
- Tried and failed treatments
- Spinal tap (if available)

MYASTHENIA GRAVIS

- Exacerbation
- Any history of crisis
- Thymectomy

- Any symptoms that affect respiration, speech or motor function
- Tried and failed treatments