Subcutaneous Immune Globulin (SCIG) Prescription Referral Form

Phone: 843-352-7662 | Fax: 866-338-4245 | 1501 Belle Isle Ave #150 Mt Pleasant SC 29464

PATIENT INFORMATION - PLEASE FORWARD FRONT AND BACK OF INSURANCE CARDS

First Name: ______________ Last Name: ______________ Date of Birth: ______________ ☐ M ☐ F

Street Address: ______________ City: ______________ State: ______________ Zip: ______________

Cell Phone: ______________ SSN: ______________ Patient Preferred Language: ☐ English ☐ Spanish ☐ ______________

PRESCRIBER INFORMATION

Name: ______________ DEA: ______________ NPI: ______________

Address: ______________

Phone Number: ______________ Fax Number: ______________ Contact Person: ______________

Office's Preferred Method of Contact: ☐ Phone ☐ Fax ☐ Portal ☐ Email: ______________ ☐ Other: ______________

PATIENT CLINICAL INFORMATION

IMMUNOLOGY: ☐ D83.9 CVID ☐ D80.0 Congenital Hypogam ☐ D80.1 Nonfamilial Hypogam ☐ D80.6 Specific Antibody Def ☐ D80.3 IgG Subclass Def ☐ D81.9 SCID

NEUROLOGY: ☐ G61.81 CIDP

OTHER: ______________

Weight: ______________ kg/lb Height: ______________ ☐ NKDA ☐ Drug Allergies: ______________

Concurrent Medications: ______________

Previous / Failed Medications: ______________

ORDERS: Subcutanenous Immunoglobulin

Medication: ______________

☐ Specific Brand Necessary (DAW) ☐ Brand Selection Permitted

SIG	QTY	RFL
☐ Infuse SCIG ______ gm/kg subcutaneously via _____ subcutaneous sites every _____ week(s)		

PRE MEDICATION

☐ Acetaminophen 325mg Tablet [Take 2 tablets by mouth 30 minutes prior to SCIG Infusion]

☐ Diphenhydramine 25mg Capsule [Take 1 capsule by mouth 30 minutes prior to SCIG Infusion]

☐ Other: ______________

ANAPHYLAXIS PROTOCOL

☐ ADULT: Epi-Pen 0.3mg Auto Injector Dual Pack [Administer intramuscularly as needed for moderate / severe ADR] | Refill PRN
Diphenhydramine 25mg Capsule #2 [Administer 25mg-50mg PO as needed for mild / moderate ADR]

☐ PEDIATRIC: Epi-Pen 0.15mg Auto Injector Dual Pack [Administer intramuscularly as needed for moderate / severe ADR] | Refill PRN
Diphenhydramine Oral [Administer 12.5mg-25mg PO as needed for mild / moderate ADR]

SUPPLIES

☒ Pharmacy to provide infusion pump and infusion pump supplies for SCIG Infusion

☒ Pharmacy to provide infusion catheter supplies for placement / maintenance of subcutaneous access

PRESCRIPTION SIGNATURE

Dispense as Written: ______________ Substitution Permitted: ______________ Date: ______________

I authorize Blue Sky Specialty Pharmacy and it's representatives to act as my agent in order to initiate and execute the insurance prior authorization process / appeals if necessary, in doing so, to release clinical information via phone / fax to appropriate third party payer

Important Notice: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you have received this communication and you are not the intended recipient, you should not disseminate, distribute, or copy this fax. Please notify sender immediately if you have received in error and then destroy this document immediately.