

Immunoglobulins (Ig) Enrollment Form - Puerto Rico



Phone: 1-888-280-1190 | 6020 Ave. Roberto Sanchez Vilella, Carolina, PR 00982

NCPDP: 4026325 | Fax enrollment form, insurance information (front/back of cards), & clinical documentation to: 1-855-297-1270

Detient Demographics						Clinical Information:		
Patient Demographics: Name DO				OB		Ht. (in/cm) Wt.(lb/kg)		
Address			Last 4-SSN					
						ICD-10 Code		
City, ST Zip Phone* Alt. Phone*			Language ☐ Male ☐ Female			Allergies		
□ patient support program info requested						access □ PIV □ CVC/PICC □ Port □ None SC		
Date S	ite of Care:	of Care:			Nursing: Specialty pharmacy will coordinate home infusion nursing for			
B. 4	Home Infusion			administration. Patient may be taught to self-infuse (SC). OK to administer first dose in the home if pharmacist deems appropriate				
Noododi	Coram Ambulatory Infusion Suite (AIS)							
	,	Prescriber office or other infusion clinic (drug only)			111151 405	e in the nome ii pharmacist deems appropriate		
Li Frescriber office of other fillusion clinic (drug offig)								
availability or payor r	equirements. IV and So	C dose rounded to the nea	arest vial	size. May infuse +/-	- 4 days p	ly appropriate substitutions allowed based on per patient schedule requests.		
Drug: Immunoglobulin Route: SC IV Dose: grams or mg/kg daily x day(s), every week(s) Other (Preferred Product):								
Additional Rx Info (Home or Coram AIS): Rx includes related diluents, pumps, DME, ancillary supplies as necessary for drug administration/catheter								
maintenance.								
Pre/Post Orders:		Dosing Protocols			Route	Directions		
Normal saline	Pre: mL			ost: mL		Administer mL/hr or over hours		
hydration		Not to be infused using	the		IV	(max rate 250mL/hr and administer via		
☐ Other:		same access as Ig		.		gravity unless otherwise specified)		
Diphenhydramine		25 \(\subseteq 50 \) mg (May be instructed to purchase at retail.) PO 30 minutes prior to infusion						
Acetaminophen	□ 325 □ 500 □ 650	\square 1000 mg (May be instru	icted to p	ourchase at retail.)		·		
Other:								
Catheter Maintenan	ce: Dispense and adm	inister based on patients'	current	access device unles	s otherwi	ise specified. Access will be PIV unless		
		V if Port or PICC failure.						
•	PIV	CVC/PICC		PORT				
Saline Flush Heparin Flush	3-5 mL	10 mL	10 mL	mL sterile to access		Administer only on drug admin days before and after drug administration, PRN to		
			10 mL Before & After		IV			
	3 mL-10 units/mL	3 mL-10 units/mL 3-5 mL 100 units/mL 3-5 mL 100 units/mL if multiple days excludes groshong		3-5 mL 100 units/mL		maintain IV access patency or obtain labs.		
	if multiple days							
Other:								
Anaphylaxis Orders (AIR): Dispense and administer based on current weight unless otherwise specified. Epinephrine autoinjector dispensed when self-administering.								
Epinephrine	Adult (>30 kg)	Pediatric (15-30kg) Infant (<15kg)		nfant (<15kg)		Administer 1 dose for moderate to severe		
	0.3 mg	0.15 mg		g/kg (Max 0.3mg)	IM/SC	allergic reaction. May repeat in 3-5 mins PRN		
Diphenhydramine	25-50 mg	1.25 mg/kg	125 m	a/ka	PO	Administer x 1 dose PO for mild reaction or		
	25 56 1119	1.25 mg/ kg	1.25 mg/kg		10	1 dose slow IV/IM for moderate to severe		
	25-50 mg	12.5 to 50 mg	1 mg/k	g	IV/IM	reaction. May repeat in 3-5 mins PRN. Max dose of 50mg.		
Other (including O2):								
		dication administration im	mediate	ly and maintain IV a	ccess dev	vice. Assess patient response. If reaction		
						te to severe symptoms occur, activate EMS		
						ment if indicated. If reaction does NOT subside,		
continue to follow BC	CLS & remain with patie	ent until EMS arrives.						
Lab Orders (Home								
or Coram AIS only):	S only): Qty: 1 month				Other	Other Refills: 1 year \square Other		
Duagavila su aismatuu		allawad). Drocoribar otto	ata ta au	namiaina thia nation	t'a madia	ally noncommutant		
Prescriber signature required (stamp not allowed): Prescriber attests to supervising this patient's medically necessary treatment. Prescriber Name NPI Phone								
State License						Fax		
_						Porcon		
Group / Hospital		Contact Person Contact Phone						
\square Dispense As Written / \square Brand Medically Necessary / \square Do No Substitute / \square No Substitution / \square DAW / \square May Not Substitute				☐ May Substitute / ☐ Substitution Perm		uct Selection Permitted /		
Prescriber's Signature: Date:								
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.								

*Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact you by phone.

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty and/or its affiliate pharmacies to complete and

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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