Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.

Intravenous Immune Globulin (IVIG) Referral Form

3233 Corporate Ct.
Ellicott City, MD 21043

LIFELINE SPECIALTY PHARMACY

Send your Rx to: **Fax Number: 410-203-1515** **Phone Number: 410-203-1010** **Toll Free Number: 1-833-4-LIFELINE** **NPI: 1568975464**

If you have questions or concerns, please contact us.

Date Medication Needed:_____ **Ship To:** ☐ Patient's Home ☐ Prescriber's Office Injection training by pharmacy? ☐

1: Patient Information

Patient Name:_____ **Birthdate:**_____ **Sex:** ☐ Male ☐ Female **Height:**_____ **Weight:**_____ ☐ lbs. ☐ kg.

Soc. Sec. #:_____ **Preferred Phone:**_____ **Known Allergies:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Alternate Caregiver Name:_____ **Preferred Phone:**_____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

Provider Name:_____ **DEA#:**_____ **NPI#:**_____ **Tax ID#:**_____

Address:_____ **Phone:**_____ **Fax:**_____

City, State, Zip:_____ **Key Contact:**_____ **Phone:**_____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

- ☐ C91.10 Chronic lymphocytic leukemia of B-cell type not having achieved remission
- ☐ D69.3 Immune thrombocytopenic purpura
- ☐ D80.0 Congenital Hypogam
- ☐ D80.2 Selective deficiency of IgA
- ☐ D80.4 Selective deficiency of IgM
- ☐ D80.5 Immunodeficiency with increased IgM
- ☐ D80.6 Antibody deficiency with near-normal Immunoglobulins or with hyperimmunoglobulinemia
- ☐ D80.7 Transient hypogammaglobulinemia
- ☐ D81.0 SCID with reticular dysgenesis
- ☐ D81.2 SCID with low or normal B cell numbers
- ☐ D81.5 Purine nucleoside phosphorylase deficiency
- ☐ D81.6 Major histocompatibility complex class I
- ☐ D81.7 Major histocompatibility complex class II
- ☐ D81.89 Other combined immunodeficiencies
- ☐ D81.9 SCID (Unspecified)
- ☐ D82.0 Wiskott-Aldrich syndrome
- ☐ D82.1 De George's syndrome
- ☐ D82.4 Hyperimmunoglobulin E syndrome
- ☐ D83.0 Common Variable Immunodeficiency with Predominant abnormalities of B cell numbers and function
- ☐ D83.1 Common Variable Immunodeficiency with predominant Immunoregulatory T cell disorders
- ☐ D83.2 Common Variable Immunodeficiency with autoantibodies to B or T cells
- ☐ D83.8 Other Common Variable Immunodeficiency D83.9 Common Variable Immunodeficiency, unspecified
- ☐ G11.3 Cerebellar ataxia with defective DNA
- ☐ G35 MS (Relapsing Remitting)
- ☐ G61.0 GBS
- ☐ G61.81 CIPD
- ☐ G61.89 MMN
- ☐ G70.00 MG without acute exacerbation G70.01
- ☐ MG with acute exacerbation
- ☐ M33.20 Polymyositis
- ☐ M33.90 Dermatomyositis
- ☐ Other ICD-Code: _____
- ☐ Prior failed medications:_____

4: Pre-medications/Adverse Reaction Medications

Medication	Route	Dose/Strength	Sig (Please specify)	Qty.	Refills
Acetaminophen	PO	☐ 325 mg ☐ 625 mg ☐ _____	☐ PRN for fever, chills, and headache: take _____ tablet(s) ☐ Other: _____		
Cetirizine	PO	☐ 10 mg ☐ _____	☐ PRN mild/mod allergic reaction: take _____ tablet(s) ☐ Other:_____		
Diphenhydramine	☐ PO ☐ IV	☐ 25 mg ☐ 50 mg ☐ _____	☐ PRN mild/mod allergic reaction: take _____ tablet(s) ☐ Premed to be given 30 minutes prior to the infusion: take ____ tablet(s) ☐ Other:		
Epinephrine	IM	☐ 0.15 mg/0.3 mL ☐ 0.3 mg/0.3 mL ☐ _____	☐ For adults weighing > or = 30kg: administer a single dose, may repeat one time ☐ For adults weighing < 30kg: administer a single dose, may repeat one time		
Fexofenadine	PO	☐ 180 mg ☐ _____	☐ PRN mild/mod allergic reaction: take _____ tablet(s) ☐ Other:_____		
Lidocaine	TOP	☐ 1.8% ☐ 5% ☐ _____	☐ Apply to injection sites at least 1 hour before ☐ Other: _____		
Methylprednisolone	IV	☐ 40 mg/mL ☐ 80 mg/mL ☐ _____	☐ PRN for mild/mod allergic reaction: Inject 125 mg slow IV push over 5 minutes ☐ Inject _____mg slow IV push over _____minutes		
Ondansetron	☐ ODT ☐ IV	☐ 4 mg ☐ 8 mg ☐ 2 mg/mL ☐ _____	☐ PRN for nausea and vomiting: take _____ tablet(s) ☐ Inject _____mg slow IV push over _____minutes		
Other: _____					

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5. Administration assistance/ Patient Support and Injection Training Authorization

☐ **Assistance required** ☐ **No, assistance needed**

I authorize Lifeline Specialty Pharmacy to enroll the patient in the pharmaceutical manufacturer support program that pertains to the prescribed therapy. The purpose of this enrollment is to assist the patient in receiving services, like injection training and administration of the therapy by a nurse. The patient also authorizes the pharmacy to transmit any pertinent information that the manufacturer needs to effectively provide the medications and services that are available with the therapy, as well as, to use unidentifiable data to conduct market research. The manufacturer may contact me with information for research and educational purposes. The patient can revoke this authorization without any effect to the patient's ability to acquire the therapy. If the patient chooses to revoke this authorization, he/she may do so by writing a letter to Lifeline Specialty Pharmacy at 3233 Corporate Court, Ellicott City, MD, 21044 .

6: Prescription Information |

Medication	Route	Dose/Strength	Sig (Please include cycle)	Qty.	Refills
ANAVIP	IV		☐ Infuse _____ vial(s) every _____ hours for _____ hours		
Atgam	IV	5 mg/mL	☐ Infuse _____mg per kg every _____days ☐ Other: _____		
CroFab	IV		☐ Infuse _____ vial(s) every _____ hours for _____ hours		
CytoGam	IV	2500 mg IgG	☐ Initial: _____mg/kg/hr for _____mins, _____mg/kg/hr for _____ mins, then _____mg/kg/hr for _____ mins to complete; Subsequent: _____mg/kg/hr for _____ mins, _____mg/kg/hr for _____ mins, then _____mg/kg/hr for _____ mins to complete		
DigiFab	IV	40 mg	☐ Infuse _____ vial(s) every _____ hours for _____ hours		
Flebogamma DIF	IV	☐ 5% (50 mg/mL) ☐ 10% (100 mg/mL)	☐ Infuse _____grams per kg every _____ weeks (inf. rate: initial _____ MD: _____) ☐ Other: _____		
Gammagard Liquid	☐ IV ☐ SQ	10% (100 mg/mL)	☐ Infuse _____grams per kg every _____ weeks (inf. rate: initial _____ MD: _____) ☐ Other: _____		
Gammaked	☐ IV ☐ SQ	10% (100 mg/mL)	☐ Infuse _____grams per kg every _____ weeks (inf. rate: initial _____ MD: _____) ☐ Other: _____		
GamaSTAN S/D	IM		☐ Administer a dose of ____ mL per kg; repeat every _____ months (if required) ☐ Other: _____		
Gamunex-C	☐ IV ☐ SQ	10% (100 mg/mL)	☐ Infuse _____grams per kg every _____ weeks (inf. rate: initial _____ MD: _____) ☐ Other: _____		
HepaGamB	☐ IV ☐ IM	☐ 1 mL ☐ 5 mL	☐ Administer a dose of _____ mL per kg or _____ mL every _____ day or _____ week from Day _____ to _____; _____		
Hizentra	SQ	20% (0.2 g/mL)	☐ Infuse _____ grams per kg _____ times every _____ weeks or _____ days ☐ Other: _____		
KEDRAB	IM	☐ 300 IU/ 2mL ☐ 1,500 IU/ 10mL	☐ Administer a dose of _____IU per kg ☐ Other: _____		
Nabi-HB	IM	☐ 1 mL ☐ 5 mL	☐ Administer a dose of _____ mL ☐ Other: _____		
Privigen	IV	10% (0.1 g/mL)	☐ Infuse _____grams per kg every _____ weeks (inf. rate: initial _____ MD: _____) ☐ Other: _____		
Rhophylac	☐ IV ☐ IM	1,500 IU (300mcg) /2mL prefilled	☐ Inject _____ IU/kg or _____ IU (inf. rate: _____ mL per _____seconds) ☐ Other: _____		
Thymoglobulin	IV	25 mg/10mL	☐ Infuse _____mg/kg daily for _____days ☐ Other: _____		
Varizig	IM	≥125 IU	☐ Based on patient's weight _____ kg: Administer a single dose of _____ IU or _____mL		
WinRho SDF Liquid	☐ IV ☐ IM	☐ 600 IU ☐ 5,000 UI ☐ 1,500 IU ☐ 15,000 UI ☐ 2,500 IU	☐ Inject _____ IU/kg or _____ mcg/kg (inf. rate: _____) ☐ Other: _____		
Other:					

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: Date:

Prescriber Signature: Prescriber, please sign and date below

Dispense as written Date Substitution Permissible Date

# of Prescriptions:____