ALLERGY PRESCRIPTION FORM

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.
Prescribers are reminded patients may choose any pharmacy of their choice.

Owl Specialty Pharmacy
1010 E. Arrow Hwy., Covina, CA 91724
Phone: 626-209-8169 Fax: 626-209-8171 or 855-817-9523
www.owlspecialty.com

Patient Information: please provide a copy of the patient's insurance card or information

Patient name:	**DOB:**	**Gender:** ☐ F ☐ M	**HT:**	**WT:**
Address:	**City:**	**State:**	**Zip Code:**	**Phone:**
Insurance:	**Subscriber's name:**	**ID#:**		**Group #:**

Allergies: ☐ NKDA ☐ List allergies:

Clinical Information: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization

Diagnosis / ICD-10:

IVIG indication required for administration: ☐ Idiopathic Thrombocytopenic Purpura ☐ Primary Immunodeficiency Syndrome ☐ Chronic Inflammatory Demyelinating Polyneuropathy ☐ Other (specify):

Vital Signs: ☐ Monitor BP q15min for the first hr of initial infusion, then q30-60min for the remainder of IVIG infusion ☐ Monitor BP q30-60min for subsequent IVIG infusions

Notify Physician if any of the following are observed: ☐ SBP is less than 90 mmHg or greater than 180 mmHg ☐ DBP is less than 50 mmHg or greater than 90 mmHg ☐ Temperature is greater than 101.5 degrees F ☐ Heart Rate is less than 50 or greater than 120 ☐ RR is less than 10 or greater than 30 respirations/min ☐ Urine Output is less than 30 mL/hr or 240 mL/shift ☐ Pulse Oximetry is less than 90% ☐ SBP is less than 90 mmHg or greater than 180 mmHg

Blood Test: CBC, Metabolic Panel (chem-7) daily, prior to each infusion, Immunofixation, Immunoglobulins quantitation (Before 1st/ _____ treatment, fax results to pharmacy

Ig Treatment

Decrease IVIG rate or stop infusion and notify physician if patient experiences adverse reactions: hypotension, chest tightness, fever, chills, or nausea/vomiting

Immune Globulin: ☐ Predisposed to renal insufficiency, minimize rate of infusion ☐ Patient has not been treated previously with IVIG, initiate at a lower concentration or lower rate

Pre-Medication: ☐ Acetaminophen 650 mg po one time 30-60 min prior to each dose of IVIG ☐ Diphenhydramine 25 mg po one time prn 30-60 min prior to each dose of IVIG ☐ Other:

Pharmacist will round down to nearest vial and maintain at least 90% of calculated dose. If dose deviates by more than 10% of calculated dose, Pharmacist may round up to nearest vial.
☐Patient has been previously treated with IVIG and tolerated therapy ☐ Patient has NOT been previously treated with IVIG ☐ Pharmacist to use current weight for dose calculations ☐ Use (specify): _____ kg as dosing weight ☐ Immune globulin 0.4 g/kg IV daily Initiate first dose at 15 to 30 mL/hr and increase rate every 30-60 minutes for duration of the infusion. For subsequent doses, titrate every 15 to 30 minutes to a final maximum rate listed in infusion table.

RX: IVIG _____ Grams _____Days Infusion Rate:_____ cc/hr for the 1st hr _____ cc/hr for the second hr _____ cc/hr thereafter

Repeat/Maintenance treatment in: _____ or every _____/ month

Dose: _____ Frequency: _____ Start Date: _____ Duration: _____

Hypersensitivity Anaphylaxis Management

Vital Signs: ☐ Vital signs every 2 minutes until stable. Then, every 5 minutes for 30 minutes, then every 15 minutes until hypersensitivity/anaphylaxis reaction subsides.	**Assessments:** ☐ Stop the administration of any agent causing hypersensitivity/anaphylaxis reaction immediately. ☐ Remain with patient, maintain airway and perform CPR if necessary.	**Interventions:** ☐ Lay patient supine with legs elevated IMMEDIATELY ☐ Oxygen therapy at 8-10 LPM via face mask
☐ Albuterol nebulization 2.5mg/3.0mL once for hypersensitivity/anaphylaxis reaction	☐ Glucagon 1 mg IV if on Beta Blockers once PRN, if patient on beta blockers and fails to respond to initial treatment	☐ Sodium chloride 0.9% bolus and infusion ☐ Sodium chloride (NORMAL SALINE) 0.9 % bolus 1,000 mL 1,000 mL, IV, once, for 30 min.
☐ Epinephrine 1:1000 (1mg/mL) injection 0.3 mg, Intramuscular, once PRN for hypersensitivity/anaphylaxis reaction. May repeat every 5-10 minutes x 3 doses. If not effective, then may give epinephrine 0.5 mg IM. Epinephrine should be administered first, as soon as the diagnosis of anaphylaxis is suspected.	☐ Epinephrine 1:1000 (1mg/mL) injection 0.5 mg, Intramuscular, once PRN for severe cases of hypersensitivity/anaphylaxis reaction. May repeat every 5-10 minutes Epinephrine should be administered first as soon as the diagnosis of anaphylaxis is suspected.	
☐ Epinephrine 1:1000 (1mg/mL) injection 0.01 mg/kg Intramuscular, once PRN for patients who weigh less than 30 kg for hypersensitivity/anaphylaxis reaction. May repeat every 5-10 minutes Epinephrine should be administered first as soon as the diagnosis of anaphylaxis is suspected.	☐ Diphenhydramine injection 50 mg IV push once PRN over 1-2 minutes for hypersensitivity/anaphylaxis reaction (25 mg/min maximum).	
☐ Loratadine 10 mg PO once for hypersensitivity/anaphylaxis reaction	☐ Methylprednisolone injection 125 mg IV once for hypersensitivity/anaphylaxis reaction	
☐ Prednisone 60 mg PO once for hypersensitivity/anaphylaxis reaction	☐ Hydrocortisone injection 100 mg IV over 30-60 seconds once PRN for hypersensitivity/anaphylaxis reaction	
☐ Famotidine 20 mg PO once PRN for hypersensitivity/anaphylaxis reaction	☐ Famotidine 20 mg IV push over 2 minutes once PRN for hypersensitivity/anaphylaxis reaction	

Non-Ig MEDICATIONS

Medication	Dose / Strength	Directions	Quantity	Refills
☐ Cinqair®	☐ 100 mg / 10 mL vial	☐ _____ mg IV every 4 weeks		
☐ Dupixent® atopic dermatitis	☐ Pen or ☐ Syringe ☐ 100 mg ☐ 200 mg ☐ 300 mg	☐ Loading dose - 2 injections SC on day 1 in two different injection sites ☐ Maintenance dose - 1 injection SC every other week		
☐ Fasenra®	☐ 30 mg/mL Autoinjector	☐ 30 mg SC once every 4 weeks for the first 3 doses, and then once every 8 weeks thereafter		
☐ Nucala®	☐ 100 mg/mL Autoinjector	☐ 100mg SC every 4 weeks		
☐ Xolair®	☐ 75 mg/mL Prefilled syringe ☐ 150 mg/mL Prefilled syringe ☐ 150 mg/mL vial	☐ _____ mg SC every 2 weeks ☐ _____ mg SC every 4 weeks		

Notes

Prescriber Information

Prescriber name:	**Phone:**	**Office contact name:**	
Prescriber address:	**City:**	**State:**	**Zip:**
NPI:	**DEA:**	**Fax and/or Email:**	
Prescriber signature:	**Date:**	☐ **DO NOT SUBSTITUTE**	