

**P:**

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

**Patient Status:** ☐ New to Therapy ☐ Continuing Therapy **Date of last infusion:** \_\_\_\_\_

## MEDICAL INFORMATION

**ICD-10 Code (required):** \_\_\_\_\_ **ICD-10 descriptions:** \_\_\_\_\_

Patient weight: \_\_\_\_\_ kg Height: \_\_\_\_\_ Diabetic: ☐ Yes ☐ No If obese, use adjusted body wt? ☐ Yes ☐ No

Allergies: \_\_\_\_\_ Brand previously used: \_\_\_\_\_

## THERAPY ORDER

☐ IV ☐ SQ **Pharmacist to identify clinically appropriate brand/infusion rates. May substitute based on product availability.**

<b>Loading Dose</b> (as applicable)	_____	<input type="checkbox"/> mg/kg <input type="checkbox"/> gm/kg <input type="checkbox"/> grams	<input type="checkbox"/> x _____ day(s) <b>OR</b> divided over _____ day(s)	<input type="checkbox"/> One time dose <input type="checkbox"/> Other: _____ Give maintenance dose _____ weeks after loading dose*
<b>Maintenance Dose</b>	_____	<input type="checkbox"/> mg/kg <input type="checkbox"/> gm/kg <input type="checkbox"/> grams	<input type="checkbox"/> x _____ day(s) <b>OR</b> divided over _____ day(s)	<input type="checkbox"/> Q _____ weeks x1 year <input type="checkbox"/> Other: _____

☐ Do not substitute. Administer brand: \_\_\_\_\_

- Infuse entire contents of Ig infusion bag/vial(s) per current dose.
- 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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Acetaminophen 500mg PO  | <input type="checkbox"/> Normal Saline 500mL IV  | <input type="checkbox"/> Cetirizine 10mg PO |
| <input type="checkbox"/> Solu-Medrol _____mg IVP | <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Cetirizine 10mg PO |
| <input type="checkbox"/> Loratadine 10mg PO      | <input type="checkbox"/> Diphenhydramine 25mg IV | <input type="checkbox"/> Other: _____       |

**Lab orders:** \_\_\_\_\_ **Lab frequency:** ☐ Each infusion ☐ Other: \_\_\_\_\_

### 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: \_\_\_\_\_ Date: \_\_\_\_\_

NP/Pharmacist Name: \_\_\_\_\_ NP/Pharmacist Signature: \_\_\_\_\_

## 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: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_

## PREFERRED LOCATION

City: \_\_\_\_\_ State: \_\_\_\_\_

Compassus

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**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