CoxHealth at Home

Subcutaneous Immune Globulin

PHONE: **1-855-419-4663**
FAX: **1-417-269-0692**

Patient information

Patient Name: _____ DOB: _____
Sex: ❑ Female ❑ Male SS #: _____
1˚ Language: _____ Wt:_____ ❑ kg ❑ lbs Ht:_____ ❑ cm ❑ in
Address: _____
Apt/Suite: _____ City:_____ State:_____ Zip:_____
Phone:_____ Alternate Phone:_____
Caregiver name: _____ Relation: _____
Local Pharmacy: _____ Phone: _____

Prescriber + Shipping Information

Prescriber Name:_____
NPI #: _____
Address: _____
Apt/Suite: _____ City:_____ State:_____ Zip:_____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email address: _____
If shipping to presciber: ❑ 1st Fill ❑ Always ❑ Never

Insurance Information (Please fax a copy of front and back of the insurance cards)

1˚ Insurance Plan: _____ Plan ID # _____ Policy Holder: _____ Relation: _____
2˚ Insurance Plan: _____ Plan ID # _____ Policy Holder: _____ Relation: _____

Clinical Information (Please fax all pertinent clinical and lab information)

ICD-10/Diagnosis Code: _____
Date of Diagnosis: _____
IgA deficiency: ❑ Yes ❑ No IgA level _____ mg/dL Date:_____
IgG trough:_____mg/dL Date:_____ Diabetic: ❑ Yes ❑ No
Has patient received immune globulin previously? ❑ Yes ❑ No
If yes, product information: _____
Date of last infusion: _____ Date of next infusion: _____
Comorbidities: _____
Allergies: ❑ NKDA ❑ Other: _____

Prescription	Drug	Dose and Directions	Quantity	Refills
Immune Globulin Products	❑ Pharmacy to determine ❑ Cuvitru 20% ❑ Hizentra 20% ❑ Gammagard 10% ❑ Gammaked 10% for Primary Immunodeficiency indication only ❑ Gamunex-C 10% Other: _____	Infuse _____ grams subq every ____ days. OR ❑ Other: _____ _____ Rate: per manufacturer's guidelines OR Other: _____ _____	28 days supply	_____
	❑ HyQvia 10%	Week 1: 1st infusion, 1-week-dose, __ grams Week 2: 2nd infusion, 2-week dose, __ grams Week 3: No infusion Week 4: 3rd infusion, 3-week-dose, __ grams Week 5: No infusion Week 6: No infusion Week 7: 4th infusion (if required), 4-week-dose, __ grams Goal dose: _____ grams subq every ___ weeks Rate: per manufacturer's guidelines OR Other: _____ _____	21-28 days supply as applicable	_____
Other Medications	❑ Acetaminophen ____ mg PO 15-30 minutes prior to infusion ❑ Diphenhydramine ____ mg PO 15-30 minutes prior to infusion ❑ Other: _____			
Skilled Nursing Visits	Skilled Nursing visit to teach self administration of subcutaneous infusion and prn if needed			

Prescriber's Signature:_____ Date: _____

I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to CoxHealth at Home.

CoxHealth