

CoxHealth at Home Subcutaneous Immune Globulin

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

Patient information	Prescriber + Shipping Information
Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SS #: _____ 1° Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate Phone: _____ Caregiver name: _____ Relation: _____ Local Pharmacy: _____ Phone: _____	Prescriber Name: _____ NPI #: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email address: _____ If shipping to prescriber: <input type="checkbox"/> 1st Fill <input type="checkbox"/> Always <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No IgA level _____ mg/dL Date: _____	Has patient received immune globulin previously? <input type="checkbox"/> Yes <input type="checkbox"/> No
IgG trough: _____ mg/dL Date: _____ Diabetic: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, product information: _____
Comorbidities: _____	Date of last infusion: _____ Date of next infusion: _____
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____	

Prescription	Drug	Dose and Directions	Quantity	Refills																															
Immune Globulin Products	<input type="checkbox"/> Pharmacy to determine <input type="checkbox"/> Cuvitru 20% <input type="checkbox"/> Hizentra 20% <input type="checkbox"/> Gammagard 10% <input type="checkbox"/> Gammaked 10% <small>for Primary Immunodeficiency indication only</small> <input type="checkbox"/> Gamunex-C 10% Other: _____	Infuse _____ grams subq every _____ days. OR <input type="checkbox"/> Other: _____ _____ Rate: per manufacturer's guidelines OR Other: _____ _____	28 days supply	_____																															
	<input type="checkbox"/> HyQvia 10%	<table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th>Week</th> <th>Infusion Number</th> <th>Dose Interval</th> <th>Dose</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>1st infusion</td> <td>1-week-dose</td> <td>__ grams</td> </tr> <tr> <td>2</td> <td>2nd infusion</td> <td>2-week dose</td> <td>__ grams</td> </tr> <tr> <td>3</td> <td colspan="3">No infusion</td> </tr> <tr> <td>4</td> <td>3rd infusion</td> <td>3-week-dose</td> <td>__ grams</td> </tr> <tr> <td>5</td> <td colspan="3">No infusion</td> </tr> <tr> <td>6</td> <td colspan="3">No infusion</td> </tr> <tr> <td>7</td> <td>4th infusion (if required)</td> <td>4-week-dose</td> <td>__ grams</td> </tr> </tbody> </table> Goal dose: _____ grams subq every _____ weeks Rate: per manufacturer's guidelines OR Other: _____ _____	Week	Infusion Number	Dose Interval	Dose	1	1 st infusion	1-week-dose	__ grams	2	2 nd infusion	2-week dose	__ grams	3	No infusion			4	3 rd infusion	3-week-dose	__ grams	5	No infusion			6	No infusion			7	4 th infusion (if required)	4-week-dose	__ grams	21-28 days supply as applicable
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Other Medications	<input type="checkbox"/> Acetaminophen _____ mg PO 15-30 minutes prior to infusion <input type="checkbox"/> Diphenhydramine _____ mg PO 15-30 minutes prior to infusion <input type="checkbox"/> Other: _____
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Skilled Nursing Visits	Skilled Nursing visit to teach self administration of subcutaneous infusion and prn if needed
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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.

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