benevere PHARMACY

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TODAY'S DATE: _____

☐ NEW PATIENT ☐ CURRENT PATIENT

# Subcutaneous Immunoglobulin Referral Form

## PATIENT INFORMATION

Patient Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

DOB _____ SSN _____

Drug Allergies _____ ☐ Male ☐ Female

Patient Weight: _____ Height: _____

## PRESCRIBER INFORMATION

Prescriber Name _____ DEA# _____

NPI# _____ Tax ID _____

Practice Name _____

Address _____ Suite _____

City _____ State _____ Zip _____

Office Phone _____ Fax _____

Office Contact _____

## INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance _____

Policy # _____ Group _____

Insurance Phone _____

Prescription Drug Coverage: Company _____

RXGRP# _____ RXBIN# _____ PCN/ID# *(if available)* _____

Secondary Insurance (if applicable) _____

Policy # _____ Group _____

Insurance Phone _____

Phone _____

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE AND PRESCRIPTION BENEFIT CARDS IF AVAILABLE

## CLINICAL INFORMATION

Diagnosis (ICD-10 Code): _____ Date Diagnosed:

Labs: IgG Level: _____ PLT Level: _____ Other: _____

New to therapy: ☐ Yes ☐ No If no, date therapy began: _____ Date of last dose: _____

Previous Treatment (reason for discontinuation): _____

Does the patient currently have an infusion pump: ☐ Yes ☐ No If yes, type of pump: _____

PLEASE ATTACH A LIST OF PATIENTS'S CURRENT MEDICATIONS.

## MEDICATIONS

☐ Gammagard Liquid 10%

☐ Gammaked Liquid 10%

☐ Gamunex–C 10%

☐ Hizentra 20%

☐ Other _____

_____

_____

☐ 0.9% Sodium Chloride flushes PRN to verify correct SC needle placement

☐ Administer first dose in home

☐ Benadryl 25 – 50 mg PO every 4-6 hours PRN itching, not to exceed 300 mg in 24 hours. Dispense 8 doses.

☑ Dispense Anaphylaxis Kit (weight/age based dosing per pharmacist)

☐ Infuse subcutaneously via the least number of sites based on the manufacturer's product packaging guidelines

☐ PRN Nursing visits for self/care-giver administration training and follow-up

☐ Standard supplies for administration as requested

☐ Sharps container

☐ Tylenol 650–1,000 mg PO every 4-6 hours PRN fever and/or headache, not to exceed 4,000mg in 24 hours. Dispense 8 doses.

☐ Other _____

_____

## PRESCRIPTION INFORMATION

Total weekly dose: _____ grams Dispense 28 day supply Goal of therapy, if applicable: _____ Refills: _____

Subcutaneous infusion to be given by: ☐ Patient ☐ Parent ☐ Other _____

☐ Patient/caregiver has received infusion training ☐ Physician's office to provide infusion training ☐ Benevere Rx to coordinate infusion training

Deliver to: ☐ Patient's home ☐ MD's Office ☐ 1st dose to MD's Office, remaining refills to patient's home Other: _____

By signing this form and utilizing our services, you are authorizing Benevere and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____