

Please fax both pages of completed form to your drug therapy team at 866.233.7151.

To reach your team, call toll-free 866.820.IVIG (866.820.4844).

Prescription & Enrollment Form

Intravenous immune globulin (IVIG)

accredo®

Four simple steps to submit your referral.

Do not contact patient, benefits check only

1 Patient Information



Please attach copies of front and back of patient's insurance cards.

New patient Current patient

Patient's first name _____ Last name _____ Middle initial _____

Male Female Date of birth _____ Street address _____

Apt # _____ City _____ State _____ Zip _____

Parent/guardian (if applicable) _____ Phone _____

Patient's primary language: English Other If other, please specify _____

2 Prescriber Information

Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office contact and title _____ Street address _____

Suite # _____ City _____ State _____ Zip _____

Phone _____ Fax _____ NPI # _____ License # _____

Infusion location: Infusion clinic Office Patient's home

If infusion clinic, address: _____

3 Clinical Information

CHECK
ONE

ICD-10 immunology: D80.0 Congenital Hypogam D83.9 CVID (unspecified) D81.9 SCID (unspecified)

ICD-10 neurology: G61.81 CIDP G61.82 MMN G35 MS (rel remit) G61.0 GBS G70.01 MG

ICD-10 rheumatology: M33.20 Polymyositis M33.90 Dermatomyositis

Other _____

Other drugs used to treat the disease _____

Weight _____ kg/lbs Height _____ cm/in Date recorded _____

NKDA Known drug allergies _____

Concurrent meds _____

Adverse reactions with previous IG treatments? _____

If so, what brand of IVIG caused the reaction? _____

4 Prescribing Information

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____
 Prescriber's first name _____ Last name _____ Phone _____

Medication	Dose	Directions
<input type="checkbox"/> Asceniv™ 10% <input type="checkbox"/> Bivigam® 10% <input type="checkbox"/> Gammagard® liquid 10% <input type="checkbox"/> Gammagard® S/D 5% <input type="checkbox"/> Gammagard® S/D 10% <input type="checkbox"/> Gammaked™ 10% <input type="checkbox"/> Gammaplex® 5% <input type="checkbox"/> Gammplex® 10% <input type="checkbox"/> Gamunex®-C 10% <input type="checkbox"/> Octagam® 5% <input type="checkbox"/> Octagam® 10% <input type="checkbox"/> Panzyga® 10% <input type="checkbox"/> Privigen® 10%	Infuse _____ grams OR _____ grams per kg OR _____ mg per kg intravenously every _____ weeks <input type="checkbox"/> Divide total dose over _____ days (where clinically appropriate, round to the nearest vial size)	Rate protocol: Titrate initial and maintenance infusions per manufacturer's product labeling. Vascular access: <input type="checkbox"/> Peripheral <input type="checkbox"/> Central <input type="checkbox"/> Port Infusion method: <input type="checkbox"/> Gravity <input type="checkbox"/> Pump
<input type="checkbox"/> Other instructions Premedication to be given 30 minutes prior to infusion: (please strike through if not required)		
<ul style="list-style-type: none"> Diphenhydramine 25mg by mouth for mild infusion reactions, may increase to 50mg for history of moderate to severe (contraindicated in patients with myasthenia gravis) Acetaminophen 650mg by mouth <input type="checkbox"/> Other _____		
For patients weighing less than 60kg, the following weight-based dosing range will be used: Acetaminophen: 10–15mg/kg		
For pediatric patients, the following weight- and age-based dosing range will be used: ≤9kg and/or <2 years old: Diphenhydramine 1mg/kg up to max of 6.25mg 2–5 years old and >9kg: Diphenhydramine 6.25mg to 12.5mg 6–12 years old: Diphenhydramine 12.5 to 25mg		
Medications to be used as needed: (please strike through if not required)		
<ul style="list-style-type: none"> Diphenhydramine 25mg by mouth every 4–6 hours as needed for mild infusion reactions, may increase to 50mg for moderate to severe; maximum of 4 doses per day (contraindicated in patients with myasthenia gravis) Lidocaine 4% applied topically to insertion site prior to needle insertion as needed to prevent site pain Acetaminophen 650mg by mouth every 4–6 hours as needed for fever, headache or chills; maximum of 4 doses per day 		
Adverse reaction medications: (keep on hand at all times)		
<ul style="list-style-type: none"> Epinephrine 0.3mg auto-injector 2-pk for patients weighing greater than or equal to 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose Epinephrine 0.15mg auto-injector 2-pk for patients weighing less than 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose Diphenhydramine 25mg by mouth for mild allergic reactions and 50mg for moderate to severe 		
Hydration Medication: <input type="checkbox"/> 0.9% Normal Saline _____ mL infused over _____ minutes <input type="checkbox"/> D5W _____ mL infused over _____ minutes Timing: <input type="checkbox"/> Pre-IG infusion _____ minutes before <input type="checkbox"/> Post-IG infusion <input type="checkbox"/> To be completed during the IVIG infusion		
Flushing orders: <ul style="list-style-type: none"> 0.9% Normal Saline 3mL intravenous (peripheral line) or 10mL intravenous (central line) before and after infusion, or as needed for line patency Heparin 10 units per mL 3mL intravenous (peripheral line) as needed for final flush Heparin 100 units per mL 5mL intravenous (central line) as needed for final flush 		
Supplies: (please strike through if not required) Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.		
Quantity/Refills: Dispense 1 month supply. Refill x 1 year unless noted otherwise. <input type="checkbox"/> Dispense 90 day supply. Refill x 1 year unless noted otherwise. <input type="checkbox"/> Other _____		
Lab orders Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy.		

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN
HERE

PHYSICIAN SIGNATURE REQUIRED

Date

Dispense as written

Date

Substitution allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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Prior authorization checklist

Primary immune deficiency disease (PIDD)

Providing Accredo with the documentation outlined in this checklist may increase the likelihood and speed of obtaining coverage for your patients with PIDD. Coverage criteria may vary by payer.

Referral form ¹ (not required for electronic prescriptions)	
	Completed Immunoglobulin (Ig) referral form (available at accredo.com)
	Copies of the front and back of all medical insurance and prescription benefits cards
Clinical documents	
	History and Physical (H&P) and progress notes (within past 6 months) Note: H&P to include documented infection history/treatment
	Pre-treatment IgG, IgA, IgM, and IgG subclass serum levels (drawn on two different occasions when available) Current IgG, IgA, IgM, and IgG subclass serum levels
	Pre- and post-antigen testing (tetanus, pneumococcal polysaccharide or H Influenza type B) AND documentation of vaccine administration date

Medicare-approved PIDD diagnosis			
D80 – Immunodeficiency with predominantly antibody defects	D81.0 – Severe combined immunodeficiency (SCID) with reticular dysgenesis	D82.0 – Wiskott-Aldrich syndrome	
D80.0 – Hereditary hypogammaglobulinemia	D81.1 – Severe combined immunodeficiency (SCID) with low T- and B-cell numbers	D82.1 – Di George's syndrome	
D80.2 – Selective deficiency of immunoglobulin A (IgA)	D81.2 – Severe combined immunodeficiency (SCID) with low or normal B-cell numbers	D82.4 – Hyperimmunoglobulin E (IgE) syndrome	
D80.3 – Selective deficiency of immunoglobulin G (IgG) subclasses	D81.5 – Purine nucleoside phosphorylase (PNP) deficiency	D83 – Common variable immunodeficiency (CVID)	
D80.4 – Selective deficiency of immunoglobulin M (IgM)	D81.6 – Major histocompatibility complex class I deficiency	D83.0 – CVID with predominant abnormalities of B-cell numbers and function	
D80.5 – Immunodeficiency with increased immunoglobulin M (IgM)	D81.7 – Major histocompatibility complex class II deficiency	D83.1 – CVID with predominant immunoregulatory T-cell disorders	
D80.6 – Antibody deficiency with near-normal immunoglobulins or with hyperimmunoglobulinemia	D81.89 – Other combined immunodeficiencies	D83.2 – CVID with autoantibodies to B- or T-cells	
D80.7 – Transient hypogammaglobulinemia of infancy	D81.9 – Combined immunodeficiency, unspecified	D83.8 – Other CVIDs	
D81 – Combined immunodeficiencies	D82 – Immunodeficiency associated with other major defects	D83.9 – CVID, unspecified	
		G11.3 – Cerebellar ataxia with defective DNA repair	

To receive in-home administration for intravenous immune globulin (IVIG) for the treatment of PIDD, Medicare Part B patients must be enrolled in the IVIG Demonstration initiative. For further information visit: <https://med.noridianmedicare.com/web/ivig>

Fax completed form to 866.233.7151.

If you have any questions, please call your Accredo Provider Support Advocate, or call 866.820.4844.

1. For referral forms visit accredo.com.

Prior Authorization Checklist

Neuromuscular Disorders¹

Providing Accredo with the documentation outlined in this checklist may increase the likelihood and speed of obtaining coverage for your patients.
Coverage criteria may vary by payer.

Referral Form (not required for electronic prescriptions)	
	Completed Immunoglobulin (Ig) referral form (available at accredo.com)
	Copies of the front and back of all medical insurance and prescription benefits cards
Clinical Documents	
	History and Physical (H&P) and progress notes ² (within past 6 months) Note: Diagnosis of the disorder must be unequivocal
	Documentation that other causes of demyelinating neuropathy have been excluded
Testing documentation:	
<input type="checkbox"/>	Electrophysiological motor-sensory nerve conduction
<input type="checkbox"/>	Electromyography (EMG)
<input type="checkbox"/>	Cerebrospinal fluid (CSF)
<input type="checkbox"/>	Biopsy (muscle-nerve) - if necessary

Additional Requirements for Myasthenia Gravis	
	Tensilon test results
	Refractory to corticosteroids over a 6 month period documentation
	Ongoing Ig treatment must be documented in H&P and progress notes ²
Additional Requirements for Polymyositis and Dermatomyositis Diagnosis	
	Creatine phosphokinase (CPK) values
	Electromyography (EMG) and/or muscle biopsy results

¹ This Neuromuscular Disorders checklist is based on Medicare Part B guidelines related to Guillain-Barre' syndrome (GBS), relapsing-remitting multiple sclerosis, chronic inflammatory demyelinating polyneuropathy (CIDP) (and variant syndromes such as Multifocal Motor Neuropathy (MMN)), myasthenia gravis, refractory polymyositis, and refractory dermatomyositis polymyositis, and refractory dermatomyositis.

² Ongoing management and documentation requirements:

- Initial improvement and continued need must be meticulously documented in progress notes
- All weaning must be attempted and documented as either amount or frequency
- Must be a stoppage in IVIG if sustained improvement is noted with weaning or no improvement has taken place at all

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