CALIFORNIA SPECIALTY™ PHARMACY

Subcutaneous Immune Globulin / Allergy

Physicians must fax the completed referral form to California Specialty Pharmacy at 866-853-6555

Your CSP Contact: _____ and Tel: _____

PATIENT INFORMATION:		**PHYSICIAN INFORMATION:** Ship to: ☐ Physician's Office ☐ Patient's Home	
Patient Name:		Physician Name:	
Address:		Address:	
City:	State: Zip:	City:	State: Zip:
Home Phone:	Alternate Phone:	Phone:	Fax:
Email:		Office Email:	
Soc. Sec #:	Weight: ____ ☐kg ☐lbs Height: ____ ☐ft ☐cm	Key Office Contact:	
Date of Birth:	Sex: ☐ Male ☐ Female BSA: ____	State LIC #: _____ NPI# _____	DEA# _____

INSURANCE INFORMATION: ☐ **DEMOGRAPHIC SHEET** ☐ **UNIVERSAL CLAIM FORM** ☐ **INSURANCE CARDS (front + back)**

*Please include demographic sheet along with Universal Claim Form for insurance records or reimbursement. (Attach Copies of cards)

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization

Diagnosis / ICD-10:		Date of Diagnosis:	Has patient received immune globulin previously? ☐ Yes ☐ No
IgA deficiency: ☐ Yes ☐ No IgA level	mg/dL Date:		If yes, product information:
Comorbidities:			Date of last infusion: Date of next infusion:
Concomitant Medications:			
Allergies: ☐ NKDA ☐ Other:			

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless noted otherwise: _____

MEDICATIONS AND DIRECTIONS

MEDICATION	DOSAGE & DIRECTIONS		QUANTITY	REFILL
☐ **Hizentra® 20%**				
Number of sites: _____	Rate: ☐ Per manufacture guidelines, as tolerated ☐ _____ Weekly SC dose = IVIG Dose (g) x 1.3 / IVIG weekly interval originally given			
☐ **Gammaked™ 10%**				
☐ **Gammagard liquid® 10%**				
☐ **Gamunex-C®**				
Number of sites: _____	Rate: ☐ Per manufacture guidelines, as tolerated ☐ _____ Weekly SC dose = IVIG Dose (g) x 1.3 / IVIG weekly interval originally given			
☐ **HyQvia® 10%**	Please complete and attach HyQvia Prescription Referral form which can be located at: http://www.hyqviahcp.com/pdf/PatientRxStartForm.pdf			
☐ **Premedication**	Acetaminophen _____ mg ☐ Premedication 30 minutes prior to infusion. ☐ Post infusion every 4-6 hours as needed for fever/headache.			
	Diphenhydramine _____ mg ☐ Premedication 30 minutes prior to infusion. ☐ Post infusion every 4-6 hours as needed for itching/site reactions.			
	☐ Lidocaine 2.5% and Prilocaine 2.5% Cream 30 grams. Apply small amount topically to insertion site(s) prior to needle insertion as needed.			
	Drug: Strength: Directions:			
☐ **Anaphylaxis Order & Medication**	Orders: 1. Stop infusion 2. Call 911 and prescribing physician 3. Administer medications below as per protocol			
	Epinephrine Auto-injector	☐ Administer 0.15 mg (15 - 30 kg) IM or subcut as needed ☐ Administer 0.3 mg (≥ 30 kg) IM or subcut as needed		
☐ **Ancillary Supplies & Equipment**	Syringe driver/pump(s) and supplies provided as needed for administration and appropriate disposal of infusion materials.			
☐ **Skilled Nursing Visits**	To train patient/caregiver in Subcutaneous Immune Globulin administration, provide education related to disease state/therapy and assess general status. Typically, 2-4 training visits required. Once trained and able to return demonstrate, patient/caregiver to self-administer Subcutaneous Immune Globulin medication independently unless otherwise specified.			
Atopic Dermatitis				
☐ **Dupixent®** (dupilumab)	☐ Inject 600 mg subcut on day 1	☐ 2 x 300 mg/2ml	PFS	0
	☐ Inject 300 mg subcut at day 15 and every 2 weeks after.	☐ 1 x 300 mg/2ml	PFS	_____
Severe Asthma				
☐ **NUCALA® (mepolizumab) 100 mg Vial**	inject 100 mg subcutaneously once every 4 weeks into the upper arm, thigh or abdomen ☐ Include Sterile water and supplies sufficient for medication days supply • One 10 mL vial sterile water for injection for every vial of Nucala dispensed • Alcohol swabs • 3 mL Luer Lock injection syringe • NDL 21G needle for reconstitution • 1 mL polyprophylene syringe with 21G to 27G x 1/2" needle for subcutaneous injection ☐ No supplies (the above supplies will be sent with shipment unless indicated)		☐ 30 day Supply ☐ 90 day Supply ☐ ___ day Supply	☐ 1 Year ☐ _____
Hereditary Angioedema (HAE)				
☐ **FIRAZYR® (icatibant)**	☐ 30mg/3ml PFS 30mg SQ in the abdominal area. If response is inadequate or symptoms recur, additional injections of 30 mg may be administered at intervals of at least 6 hours. Do not administer more than 3 injections in 24 hours		3 Prefilled Syringes	
☐ **Others**				

Prescriber Signature Required ***Prescription is void if the number of drugs prescribed is not noted**

I authorize California Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Prescriber Signature	Date	NO. OF DRUGS PRESCRIBED _____ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5