ProsperInfusion

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Primary Immune Deficiency

Patient Information

Patient Name:______________________ Date of Birth:______________

Sex: ☐ M ☐ F

Language: _____________ Wt: ______ ☐ kg ☐ lbs Ht:_____ ☐ in ☐ cm

Address: ____

Apt/Ste:______ City:_____________________ St:______ Zip:_________

Phone:_______________________ Alternate:____________________

Caregiver Name:_____________________ Relation:________________

Local Pharmacy:_____________________ Phone:__________________

Prescriber Information

Prescriber Name:____

NPI:____

Address: ____

Apt/Ste:______ City:_____________________ St:______ Zip:_________

Contact:____

Phone:_______________________ DEA No.:______________________

Fax:____

Email Address:____

Statement of Medical Necessity: Primary Diagnosis Description and ICD-10 Code

Common Variable Immunodeficiency (CVID)

Diagnosis	Code
☐ With Predominant Abnormalities of B-cell numbers and function	D83.0
☐ With Predominant Immunoregulatory T-Cell Disorders	D83.1
☐ With Autoantibodies to B or T Cells	D83.2
☐ Other Common Variable Immunodeficiency (CVID)	D83.8
☐ Common Variable Immunodeficiency (CVID), unspecified	D83.9
☐ Major Histocompatibility Complex Class I Deficiency	D81.6
☐ Major Histocompatibility Complex Class II Deficiency	D81.7

Severe Combined Immunodeficiency (SCID)

Diagnosis	Code
☐ With Reticular Dysgenesis	D81.0
☐ With low T and B-cell numbers	D81.1
☐ With low or normal B-cell numbers	D81.2
☐ Other Combined Immunodeficiency	D81.89
☐ Combined Immunodeficiency, Unspecified	D81.9
☐ Hereditary Hypogammaglobulinemia	D80.0
☐ Nonfamilial Hypogammaglobulinemia	D80.1

Diagnosis	Code
☐ Immunodeficiency with Increased IgM	D80.5
☐ Selective Deficiency of IgA	D80.2
☐ Selective Deficiency of IgM	D80.4
☐ Wiskott-Aldrich Syndrome	D82.0
☐ Selective Deficiency of IgG subclasses	D90.3
☐ Other: ________________________	______

Prescription Orders

Administer IVIG Product: **Pharmacist to Determine** **Brand:**_______________________

Dose:** (please select one and complete; dosing will be based on actual body weight unless further specified)

☐ **Intravenous:______ mg/kg IVIG via pump or gravity every _____ weeks for _____ cycles**

☐ **Subcutaneous:______ mg/kg SCIG via Freedom 60 pump divided into weekly doses for _____ cycles**

☐ **Other Regimen:** ____ **Refills** _______

***Dispense 4-week supply. IV doses rounded to nearest 5-gm, SC doses rounded to nearest 1gm*

First Dose: ☐ **Yes** ☐ **No**

If No, First Date Given:_______________________

Target Start Date:___________________________

Next MD Appointment:_______________________

Other Orders/Notes:____

____

☐ **NKDA** ☐ **Allergies:**____

Initiate Appeals Reason:____

Patient Records ***(Please Attach and Fax)***

1. Insurance Card(s) and Demographic Information
2. Recent Clinical Assessment Note or H&P
3. Current Medication List
4. Diagnostic & Laboratory Tests

Access: ☐ **Peripheral** ☐ **PICC** ☐ **Port** ☐ **Other:** ____________________________

Prosper Infusion Flushing Protocol is the following (dispense #QS per pharmacy protocol):

NS Flushes (10mL)
PIV: 3mL to 5mL IV pre/post + PRN
PAC: 10 mL IV pre/post + PRN

Adult: Heparin 100 units/mL
PIV: 3mL IV post + PRN to maintain catheter patency
PAC: 5mL IV post + PRN to maintain catheter patency

Pediatric: Heparin 10 units/mL
PIV: 3mL post + PRN to maintain catheter patency

Adverse Reaction/Anaphylaxis kit will include one of each of the following per day of treatment (including all supplies for administration), except Epinephrine, which will only be a one-day supply (dispense #QS per pharmacy protocol):

- Diphenhydramine 25 mg capsules and 1 mg/mL vials, 0.9% NaCl 500 mL bags, and 2 x epinephrine 1 mg/mL (1:1000) ampules
  Sig: U.D. PRN adverse reaction and/or anaphylaxis per pharmacy protocol

Pretreatment Medications (administer 15-30 minutes before each infusion starts, dispense #QS)

☐ APAP 500 MG, ___ tablet(s) PO before infusion ☐ Diphenhydramine 25 mg PO before infusion ☐ Other:_______________________

☐ APAP 325 MG, ___ tablet(s) PO before infusion ☐ Aspirin 325 MG, ____ PO tablet(s) before infusion ☐ None

Labs (Results will be faxed to physician's office. Labs will not be drawn on weekends or holidays. Not appropriate for STAT labs):

☐ MD Office to Manage Labs

☐ Prosper Infusion Lab Protocol (IV Patients Only): CBC, BUN, Cr, at day 1 of first infusion, then every 3rd cycle. IgG levels drawn at 3rd cycle only.

Physician Signature:____ Date:_______________________

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

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