Xembify® Infusion

Fax Referral To: 877-438-9380

ContinuumRx Specialty Infusion Services

Birmingham,AL	Huntsville, AL	Knoxville, TN	Nashville, TN	Chantilly, VA
F: 205-271-9971	F: 256-417-6408	F: 865-934-0249	F: 615-645-4791	F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ◯ N ◯ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis: _____Other: _____

Please attach the following: 1. Clinical progress notes and H&P to support diagnosis 2. Copy of the patient's Insurance Card 3. Copy of any recent Labs, etc.

Lab Orders: _____

Physician Information

Prescribing Physician: _____ Practice Name: _____

Practice Phone: _____ Practice Fax: _____

Email: _____ Office Contact: _____

Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **Xembify®** ***(immune globulin subsutaneous human-klhw) 20%***

_____ # Refills (Dispense 1 month supply. Refill x 1 year unless noted otherwise.)

☐ ***New Start:***

Infuse _____ gram(s)
OR _____ mg per kg OR
OR _____ grams per kg subcutaneously

☐ Once weekly ☐ Every 2 weeks
☐ Other frequency: _____
(where clinically appropriate, round to the nearest vial size)

Infuse total dose of immune globulin subcutaneously in 1 to multiple sites via infusion pump as tolerated. Infusion rates per manufacturer recommendation as tolerated.

☐ 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 650 mg PO administered 30 min prior to infusion **adjust to patient's needs.*
☐ Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date