HERITAGE SPECIALTY PHARMACY

At Home Program - CIIC
Patient Referral Form

Admissions Phone: 855-937-7273
Admissions Fax: 844-878-6917

Patient Demographics Information

Patient Name		SSN#	DOB
Patient Address			
Primary Phone	Cellular Phone	Work Phone	
CIIC At Home Program Provider Name		Provider Contact Number	
Emergency Contact Name & Relationship		Emergency Contact Number	

Additional Documentation Needed

- Patient facesheet with demographics
- History and physical
- CBC w/ diff, BMP & CMP (within 1 year)
- For immune deficiency, detailed infection history, IgG and IgA levels, and vaccine responses
- Vital signs including blood pressure

Patient Clinical Information

Gender	Height (in.)	Weight (lbs)	Allergies (food/drug)

Statement of Medical Necessity / Primary Diagnosis

ICD10:	Description of diagnosis:

Subcutaneous Immunoglobulin - Medication Information/Prescription and Orders

Medication:	**Dose:**	**Directions:**	**Quantity / Refills**
☐ Cutaquig 16.5% ☐ Cuvitru 20% ☐ Gammagard 10% ☐ Gammaked 10% ☐ Gamunex-C 10% ☐ Hizentra 20% PFS ☐ HyQvia 10% ☐ Xembify 20%	**Loading**: _____ grams subcutaneously, given over _____ days (_____ g/day) **Maintenance:** _____ grams subcutaneously every _____ week(s)	Infuse subcutaneously per manufacturer guidelines OR over _____ hours. *Pharmacy to provide all necessary supplies to complete infusion per manufacturer guidelines and provider order.	Dispense: 1 months supply, refill x12mo. unless otherwise noted ☐ Other

Premedication(s)

☐ Give premedication(s) 30 minutes prior to infusion (generics will be dispensed)

Acetaminophen:	☐ 325mg tab: 325mg-650mg PO	☐ 160mg/5mL oral susp: _____ mg PO	Dispense: Quantity #QS, refills PRN unless otherwise noted ☐ Other
diphenhydrAMINE:	☐ 25mg cap: 25mg-50mg PO	☐ 12.5mg/5mL oral liquid: _____ mg PO	

*If subsequent treatment only -- Date of last infusion _____ Date next infusion due _____

Injectable Biologics - Medication Information/Prescription and Orders

Medication:	**Dosage Form:**	**Dose and Directions:**	**Quantity / Refills**
☐ Fasenra (benralizumab)	☐ 10mg/0.5mL prefilled syringe ☐ 30mg/mL prefilled syringe	Inject _____ mg subcutaneously every _____ week(s)	Dispense: 1 month supply Refill: x12 months unless otherwise noted ☐ Other
☐ Nucala (mepolizumab)	☐ 40mg/0.4mL prefilled syringe ☐ 100mg/mL prefilled syringe	Inject _____ mg subcutaneously every _____ week(s)	
☐ Xolair (omalizumab)	☐ 75mg/0.5mL prefilled syringe ☐ 150mg/mL prefilled syringe ☐ 300mg/2mL prefilled syringe	Inject _____ mg subcutaneously every _____ week(s)	
☐ Tezspire (tezepelumab)	☐ 210mg/1.91mL prefilled syringe	Inject _____ mg subcutaneously every _____ week(s)	

*Pharmacy to provide all necessary supplies to complete infusion per manufacturer guidelines and provider order.

*If subsequent treatment only -- Date of last injection _____ Date next injection due _____

Prescriber Information

Ordering Provider Name	NPI#	Office/Clinic Contact	
Clinic Name		Clinic Phone	
Clinic Address		Clinic Fax	
Provider Signature Required - Substitution Permitted	Date	Provider Signature Required - Dispense as Written	Date