ALLERGY & IMMUNOLOGY ENROLLMENT FORM

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ALTHEA
INFUSION & SPECIALTY PHARMACY™

Patient Name: _____ DOB: / / Height: _____ Weight: _____kg Date: / /

Allergies: _____ Email: _____

Address: _____ Ph: _____

Prescriber: _____ Ph: _____ Fax: _____

Ship to:
- ☐ Patient
- ☐ MD Office
- ☐ Althea Location: _____

DOCUMENTS TO INCLUDE WITH REFERRAL

- Patient demographics
- Face sheet
- Insurance information
- **Labs**: CBC with differential
- - Quantitative immunoglobulins (IgG, IgA, IgM)
- - Antibody titers (e.g., pneumococcal, tetanus)
- - Hepatitis B & C panel
- - TB screening (Quantiferon or TST)
- - HIV screening
- - Serum IgE or eosinophil count (if applicable)
- H&P
- Medications and therapies tried and failed
- Baseline assessment, including detailed patient symptoms
- Attach original prescription orders

DIAGNOSIS

- ☐ D83.0 – Common Variable Immunodeficiency (CVID)
- ☐ D80.3 – Selective Deficiency of IgG
- ☐ D75.82 – Immune Thrombocytopenia (ITP)
- ☐ G04.81 – Autoimmune Encephalitis Severe Plaque Psoriasis
- ☐ L40.50 Psoriatic Arthritis
- ☐ J45.50 – Severe Persistent Asthma, Uncomplicated
- ☐ L50.1 – Idiopathic Urticaria
- ☐ K20.0 – Eosinophilic Esophagitis
- ☐ Other _____

IMMUNE GLOBULIN PRESCRIPTION (IVIG)

Loading Dose: ____ grams/kg infused over ____ day(s)
____ grams daily for ____ day(s)

Maintenance: ____ grams/kg infused over ____ day(s)
____ grams daily for ____ day(s)

☐ Repeat course every ____ week(s) refill x 1year

Brand Name: _____

SUBCUTANEOUS IMMUNE GLOBULIN PRESCRIPTION (SCIG):

SCIG ____ grams monthly **OR** ____ grams every ____ weeks. Refill x 1year. Pharmacy to select number of infusion sites and needle length.

Multiple doses will be administered on consecutive days unless ordered otherwise. ☐ **Non-consecutive days OK**

OK to round to the nearest vial size.+/- 4 days to allow scheduling flexibility.

ASTHMA/IMMUNOLOGY PRESCRIPTION — DOSAGE AND ADMINISTRATION

☐ Cinqair® (reslizumab)	3 mg/kg IV every 4 weeks Infuse over 20–50 minutes
☐ Benlysta® (belimumab)	LOADING DOSE: 10mg per kg at 2 week intervals for the first 3 doses MAINTENANCE DOSE: 10mg per kg at 4 week intervals thereafter
☐ Soliris® (eculizumab)	LOADING DOSE: 900 mg IV once weekly × 4 doses (administered at weeks 0, 1, 2, and 3) MAINTENANCE DOSE: 1200 mg IV every 2 weeks, starting at week 5
☐ Rituxan® (rituximab) ☐ Ruxience® (rituximab-pvvr) ☐ Truxima® (rituximab-abbs)	LOADING DOSE: 375 mg/m² IV once weekly × 4 doses MAINTENANCE DOSE: 1,000 mg IV every 6 months
☐ Uplizna® (inebilizumab)	LOADING DOSE: 300 mg IV on Day 1 and Day 15 (2 doses, 2 weeks apart) MAINTENANCE DOSE: 300 mg IV every 6 months, starting 6 months after the first infusion
☐ Other	_____

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol - Flushing per S.A.S.H. protocol (Saline, Administer medication, Saline, Heparin) specific volumes and concentrations based on patient's line type.

Premedications & Other Medications - Infusion supplies as per protocol. Anaphylaxis Kit orders as per protocol.

☐ Acetaminophen ____mg PO prior to infusion ☐ Diphenhydramine ____mg PO ☐ Other: _____