

ALLERGY & IMMUNOLOGY ENROLLMENT FORM

Ph: 949.667.4325 | Fax: 714.485.7063 | altheainfusion.com | altheapharmacy.com



Patient Name: _____ DOB: ____ / ____ / ____ Height: _____ Weight: _____ kg Date: ____ / ____ / ____
 Allergies: _____ Email: _____ Ship to: Patient
 Address: _____ Ph: _____ Prescriber Signature MD Office
 Prescriber: _____ Ph: _____ Fax: _____ 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 1 year

SUBCUTANEOUS IMMUNE GLOBULIN PRESCRIPTION (SCIG):

SCIG _____ grams monthly **OR** _____ grams every _____ weeks.
 Refill x 1 year. 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**

Brand Name: _____

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 x 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/m ² IV once weekly x 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: _____