ALLERGY & IMMUNOLOGY ENROLLMENT FORM

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ALTHEA
INFUSION & SPECIALTY PHARMACY

Patient Name: | **DOB:** | **Height:** | **Weight (kg):** | **Date:**

Allergies: | **Email:** | **Phone:**

Address: | **Ship to:** ☐ Patient ☐ MD Office ☐ Althea Location

DIAGNOSIS (ICD-10) — check all that apply

- ☐ D83.0 – Common Variable Immunodeficiency (CVID)
- ☐ D80.3 – Selective Deficiency of IgG
- ☐ D69.3 – Immune Thrombocytopenic Purpura (ITP)
- ☐ G04.81 – Autoimmune Encephalitis
- ☐ L40.0 – Plaque Psoriasis
- ☐ L40.50 – Psoriatic Arthritis
- ☐ J45.50 – Severe Persistent Asthma, Uncomplicated L50.1 – Idiopathic Urticaria
- ☐ K20.0 – Eosinophilic Esophagitis
- ☐ M32.9 – Systemic Lupus Erythematosus (SLE)
- ☐ D59.5 / D59.39 – Paroxysmal Nocturnal Hemoglobinuria (PNH) / Atypical HUS
- ☐ M31.30 – Granulomatosis with Polyangiitis (GPA/MPA)
- ☐ D89.84 – IgG4-Related Disease (IgG4-RD)
- ☐ J33.9 – Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
- ☐ Z91.018 – IgE-Mediated Food Allergy
- ☐ Other:

IMMUNE GLOBULIN PRESCRIPTION (IVIG / SCIG)

IVIG Brand: ☐ Octagam 5% ☐ Octagam 10% ☐ Panzyga 10% ☐ Privigen 10% ☐ Gammagard 5% ☐ Gammagard 10% ☐ Gamunex-C 10%

Route: ☐ IVIG ☐ SCIG **Preferred Brand:** ☐ Pharmacist to determine ☐ Specify: _____

Product: _____ **Dose:** _____ g/kg **Frequency:** _____ **Qty:** _____ ***Refills:** _____

Substitution Permitted: ☐ Yes ☐ No **Infuse Over:** _____ days **Max Rate:** _____ cc/hr

ALLERGY/IMMUNOLOGY PRESCRIPTION — DOSAGE AND ADMINISTRATION

Cinqair ® (reslizumab)	3 mg/kg IV every 4 weeks. Infuse over 20–50 minutes.
☐ **Benlysta ®** (belimumab)	Loading: 10 mg/kg IV at 2-week intervals for the first 3 doses. Maintenance: 10 mg/kg IV at 4-week intervals thereafter.
Soliris ® (eculizumab)	Loading: 900 mg IV once weekly x4 doses (weeks 0, 1, 2, and 3). Maintenance: 1200 mg IV every 2 weeks, starting at week 5.
Rituxan ® (rituximab) ☐ **Ruxience ®** (rituximab-pvvr) ☐ **Truxima ®** (rituximab-abbs)	Induction: 375 mg/m2 IV once weekly x4 doses. Follow-up: two 500 mg IV infusions 2 weeks apart, then 500 mg IV every 6 months thereafter.
Uplizna ® (inebilizumab)	Loading: 300 mg IV on Day 1 and Day 15 (2 doses, 2 weeks apart). Maintenance: 300 mg IV every 6 months, starting 6 months after the first infusion.
Xolair ® (omalizumab)	SC injection every 2–4 weeks; dose (75–600 mg per visit, as 1–4 injections) is set by baseline body weight and serum total IgE per FDA dosing table. Retest IgE if therapy interrupted ≥ 1 year.

☐ **Other:** _____

PREMEDICATION ORDERS / OTHER MEDICATIONS

Flush Protocol — per S.A.S.H. (Saline, Administer med, Saline, Heparin), volumes/concentrations per line type. Anaphylaxis Kit orders as per protocol below.

Refills entered in the Prescription section above also apply to premedications.

☐ Acetaminophen ☐ mg PO ☐ Diphenhydramine ☐ mg PO/IV ☐ Methylprednisolone _____ mg PO/IV

☐ Other: _____

ANAPHYLAXIS KIT & HYDRATION STANDING ORDERS

Authorizes RNs/LVNs to administer the following without a separate patient-specific order, per protocol, for 1 year from signature date.

Anaphylaxis Kit — check to authorize:

- ☐ Epinephrine 1:1000, 0.3 mg IM; may repeat q5-15 min PRN
- ☐ Sodium Chloride 0.9%, 500 mL IV bolus x1
- ☐ Methylprednisolone 125 mg IV push x1
- ☐ Diphenhydramine 50 mg IV or IM x1

Hydration Kit — base fluid always given; check to remove:

Base: Sodium Chloride 0.9%, 500 mL IV over 30 min

- ☐ Remove Vitamin B-12 1,000 mcg
- ☐ Remove Calcium Gluconate 180 mg
- ☐ Remove Magnesium Chloride 800 mg
- ☐ **DO NOT INFUSE hydration kit for this patient**

Infusion Reaction Protocol — check to authorize:

Vitals per protocol: prior to infusion, q15 min during rate escalation, hourly thereafter, and at completion. Watch for dyspnea or rash.

For any reaction: stop infusion and administer meds as applicable, then notify prescriber.

- ☐ Acetaminophen 325 mg PO for headache, temp > 101°F
- ☐ Methylprednisolone IV for persistent or severe reaction
- ☐ Diphenhydramine 25 mg PO or Loratadine 10 mg PO for itching/rash

If symptom resolves, resume treatment at 50% rate after 30 min, then titrate to patient tolerance. If severe/symptomatic, do not restart.

CLINICAL PARAMETERS & HOLD CRITERIA

Hydration Kit — do NOT infuse if:

Vitals: SBP > 160, DBP > 100, or HR > 100 bpm
Labs: Ca > 10.5, Mg > 2.6, eGFR < 90, or BNP > 100
Pregnancy/breastfeeding; signs of CHF, ESRD, liver cirrhosis, or shortness of breath/edema

Anaphylaxis — initiate immediately if rapid onset of:

Respiratory: wheezing, stridor, throat tightening, or SpO2 < 92%
Circulatory: SBP < 90 (or drop > 20 w/ symptoms), HR > 110, or syncope
Skin/GI: angioedema, generalized hives, severe cramps

Emergency sequence: Stop infusion (keep IV access) → Call 911 → Give epinephrine IM → Do not restart infusion → Monitor vitals q1–2 min, transport via EMS, and notify prescriber and pharmacy in SBAR format once stable.

PRESCRIBER AUTHORIZATION

By signing below, I authorize Althea Infusion & Specialty Pharmacy to dispense the immune globulin and/or neurology prescription(s) indicated above, and I authorize California-licensed RNs/LVNs to administer the Anaphylaxis Kit and Hydration Kit standing orders as indicated above. I assume clinical responsibility for these orders, which remain in effect for 1 year from the date below or until rescinded by me in writing.

Prescriber Name: | **NPI:** | **DEA:** | **CA Lic:**

Phone: | **Fax:** | **Specialty:**

Prescriber Signature: | **Date:**