EPS Rx
A CarePartners Pharmacy Company

CarePartners
Specialty Infusion

Phone : 844-800-5377 Fax : 214-782-9155

MATERNAL-FETAL MEDICINE RX ENROLLMENT FORM

PATIENT INFORMATION

Patient Name:		Date of Birth:	Gender:
Home Phone:	Cell Phone:	Email:	
Address:	City:	State:	Zip:
Emergency Contact:		Emergency Phone:	

CLINICAL INFORMATION

Patient Weight:________ ☐ kg ☐ lbs
Patient Height:________ ☐ cm ☐ in
Allergies:________
Current Gestational Age: ________ EDC: ________
Gravida:________ Para:________
Has patient previously received IG? ☐ Yes ☐ No
☐ Pharmacy to coordinate home health nursing visit and/or nursing training

PRESCRIBER INFORMATION

Prescriber Name: ________
DEA #: ________ NPI #: ________
Address: ________
City: ________ State: ________ Zip: ________
Phone:________ Fax: ________
Contact Person: ________

PRESCRIPTION INFORMATION **Pharmacy to select IG if medication left blank**

MEDICATION ☐ **Pharmacy to select IG** ☐ Brand ________

Dose and Directions

Infusion Start Date: ________

☐ Infuse ________ GRAMS IV daily for ________ day(s),

every ________ week(s) x ________ cycles

☐ Other ________

☐ +/- 4 days to allow scheduling flexibility ☐ OK to round to the nearest vial size
Multiple doses will be administered on consecutive days unless ordered otherwise.
Rate protocol: Titrate initial and maintenance infusions per manufacturer's product labeling.

DIAGNOSIS

☐ D69.3 Immune Thrombocytopenic Purpura (ITP)
Platelet Count:________
Date:________

☐ P78.84 Gestational Alloimmune Liver Disease (GALD)

☐ O36.191 Maternal care for other isoimmunization, 1st trimester

☐ P61.0 Transient Neonatal Thrombocytopenia (NAIT)
Has HPA-1a testing been completed? ☐ Yes ☐ No
Results Confirm NAIT: ☐ Yes ☐ No

☐ Other ________

REQUIRED FOR HOME INFUSION **RX to include diluents, needles, syringes, ancillary supplies, home medical equipment to administer infusion.**

IV Access	**To be administered PERIPHERALLY, unless otherwise indicated.** ☐ PORT ☐ PICC
Flush Protocol for IVIG drug admin days only	• 0.9% NaCl: 1-10mL IV before/after infusion, or PRN for line patency/SASH. • Heparin 10 units/mL: 5mL IV (peripheral) PRN for final flush. *For multi-day infusions • Heparin 100 units/mL: 5mL IV (central) PRN for final flush. * For multi-day infusions, peripheral IV to be obtained, maintained, and discontinued for the duration of the infusion cycle per RN discretion in accordance with INS guidelines.
Pre and Post Medications Please strikethrough if not required	**To be given by mouth 30 minutes prior to infusion. May repeat every 4-6 hours as needed.** **Diphenhydramine** 25mg-50mg Adult max: 100mg/day **Acetaminophen** 325mg-650mg Adult max: 3000mg/day
Anaphylaxis Protocol	**To be given intramuscularly PRN severe allergic reaction. Call 911. May repeat x 1.** • Epinephrine 0.3mg (≥30kg/66lbs)
Hydration Please select only if needed for IVIG	☐ 0.9% NaCl ______mL infused over ______ minutes ☐ D5W ______ mL infused over ______ minutes **To be infused pre-infusion, unless otherwise indicated.** ☐ Concurrent with Infusion ☐ Other ______ Nurse to determine hydration rate if rate not provided above.
Diphenhydramine Please select only if needed for IVIG	**To be given via slow IV push PRN for moderate – severe reaction.** ☐ 25-50mg ☐ Other______
Quantity and Refills	Dispense 1-month supply. Refills:______
Additional Orders	

PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

☐ May Substitute/Product Selection Permitted/Substitution Permissible
Prescriber Signature ________ **Date** ________

☐ Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute
Prescriber Signature ________ **Date** ________

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" ________ **NY & Iowa** providers, please submit electronic prescription.

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