GAMMAGARD LIQUID
[Immune Globulin Infusion (Human)] 10%

MMN PRESCRIPTION REFERRAL FORM

PREVENT SUBSTITUTIONS
Write "Dispense as Written"

Fax completed form to (855) 217-1619

HOW CAN MYIGSOURCE HELP YOU? ☐ Register Only ☐ New Patient ☐ Continuing Patient ☐ Conversion Patient ☐ Refer to Homecare ☐ BV Only

SECTION A
PATIENT INFORMATION (REQUIRED)

PATIENT NAME: DATE OF BIRTH: SEX (M/F):

ADDRESS: CITY: STATE: ZIP:

TELEPHONE: E-MAIL:

PARENT/GUARDIAN NAME: DIAGNOSIS CODE: *LIST MULTIPLE CODES IN PRIORITY ORDER*

REQUIRED IF PATIENT IS YOUNGER THAN 18 YEARS

☐ ENGLISH IS 2ND LANGUAGE PRIMARY LANGUAGE: CURRENT TREATMENT:

SECTION B
INSURANCE INFORMATION

If benefits processing is requested, please provide a copy (front & back) of insurance card or of any medical and/or prescription cards.

PRIMARY INSURANCE:

TELEPHONE: FAX:

INSURED'S NAME:

RELATIONSHIP TO PATIENT: EMPLOYER:

GROUP #: IDENTIFICATION #:

SECONDARY INSURANCE:

TELEPHONE: FAX:

INSURED'S NAME:

RELATIONSHIP TO PATIENT: EMPLOYER:

GROUP #: IDENTIFICATION #:

SECTION C
PRESCRIBER PREFERENCE

PREFERRED SITE OF CARE (MARK ONE):

☐ Infusion suite ☐ Hospital outpatient ☐ Prescriber's office ☐ Home Infusion ☐ Begin treatment in clinical setting, then transition to homecare

PREFERRED INFUSION PROVIDERS : SPECIALTY PHARMACY/HOMECARE COMPANY TO TRAIN PATIENT? _____YES _____NO

WOULD YOU LIKE THE INFUSION PROVIDER TO CONTACT YOU REGARDING NURSING NOTES/PHARMACY PROGRESS REPORTS ON THE STATUS OF THE PATIENT? _____YES _____NO

SECTION D
PRESCRIPTION/ MEDICAL ORDERS

For Intravenous Administration Only.

For patients with MMN, dose range is 0.5 to 2.4 g/kg/month based on clinical response.[1] In order to avoid worsening of muscle weakness in patients, dose adjustment may be necessary.[1]

PATIENT WEIGHT: _____[kg] ORDERED DOSE: _____[g/kg] DIVIDED OVER: _____day(s) FREQUENCY: _____

ROUTE: ☐ Central line ☐ Peripheral IV

REFILLS: _____ times (as allowed by state or payer requirement)

OTHER MEDICATIONS: _____ DRUG ALLERGIES: _____

ADDITIONAL SERVICES

☐ Provide needles, syringes, venous access devices (VAD) & other ancillary supplies needed for infusion

☐ Anaphylaxis kit: _____

☐ Nursing services: Skilled nursing visit to establish venous access, patient education related to treatment & disease state, administer medication as prescribed, assess general status, and response to treatment. Visit frequency based on prescribed dosage orders.

SECTION E
PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME: OFFICE CONTACT:

ADDRESS: CITY: STATE: ZIP:

TELEPHONE: FAX: E-MAIL:

FACILITY OR PRESCRIBER TAX ID #: DEA #: NPI #:

PLEASE NOTE: TWO SIGNATURES ARE REQUIRED

- I verify that the patient has been informed of the diagnosis listed in Section A of this form.
- I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed GAMMAGARD LIQUID based on my professional judgment and medical necessity. I authorize Baxter Healthcare Corporation and its affiliated companies, agents and representatives, and contracted third parties ("Baxter and Baxter Parties") to contact my patient regarding Baxter programs, and to forward this prescription electronically, by facsimile, or by mail to the dispensing pharmacy selected above (if applicable). I authorize the dispensing pharmacy to share information with Baxter and Baxter Parties about this patient. I also authorize Baxter and Baxter Parties to perform any steps necessary to obtain reimbursement for GAMMAGARD LIQUID, including but not limited to insurance verification and case assessment. I understand that additional information may be required, and I agree to provide it as needed for the purposes of reimbursement.

☐ **DISPENSE AS WRITTEN** Exact terminology may be based on state regulations. Please provide state-specific prescription language here: _____

PRESCRIBER SIGNATURE (REQUIRED): DATE: EN (FOR INTERNAL PURPOSES ONLY):

PRESCRIBER AUTHORIZATION (REQUIRED)

By signing below, I certify that I have received the necessary written authorization from the patient to release the medical and/or patient information referenced on this form relating to the above-referenced patient to Baxter Healthcare Corporation and it's affiliated companies, agents and representatives, and contracted third parties for all of the purposes I authorize above, including seeking reimbursement support, verifying insurance coverage and/or the evaluation of the patient's eligibility for alternate sources of funding, contacting the patient for the purpose of enrollment in Baxter patient support services, and to facilitate materials fulfillment and product fulfillment via dispensing pharmacies..

PRESCRIBER SIGNATURE (REQUIRED): DATE:

For more information, call MyIgSource at 855-250-5111 or visit www.gammagard.com

Please see the Indication and Detailed Important Risk Information on reverse side of this form and accompanying full Prescribing Information, including boxed warning.

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GAMMAGARD LIQUID
[Immune Globulin Infusion (Human)] 10%

Indication

GAMMAGARD LIQUID is indicated as a maintenance therapy to improve muscle strength and disability in adult patients with Multifocal Motor Neuropathy (MMN).

Detailed Important Risk Information

WARNING: THROMBOSIS, RENAL DYSFUNCTION and ACUTE RENAL FAILURE

- **Thrombosis may occur with immune globulin products, including GAMMAGARD LIQUID. Risk factors may include advanced age, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling vascular catheters, hyperviscosity, and cardiovascular risk factors. Thrombosis may occur in the absence of known risk factors.**
- **Renal dysfunction, acute renal failure, osmotic nephrosis, and death may occur in predisposed patients with immune globulin intravenous (IGIV) products including GAMMAGARD LIQUID. Renal dysfunction and acute failure occur more commonly with IGIV products containing sucrose. GAMMAGARD LIQUID does not contain sucrose.**
- **For patients at risk of thrombosis, administer GAMMAGARD LIQUID at the minimum dose and infusion rate practicable. Ensure adequate hydration in patients before administration. Monitor for signs and symptoms of thrombosis and assess blood viscosity in patients at risk of hyperviscosity.**

CONTRAINDICATIONS

GAMMAGARD LIQUID is contraindicated in patients who have a history of anaphylactic or severe systemic hypersensitivity reactions to the administration of human immune globulin. GAMMAGARD LIQUID is contraindicated in IgA-deficient patients with antibodies to IgA and a history of hypersensitivity.

WARNINGS and PRECAUTIONS

HYPERSENSITIVITY: IgA deficient patients with antibodies to IgA are at greater risk of developing potentially severe hypersensitivity and anaphylactic reactions. In case of hypersensitivity, discontinue GAMMAGARD LIQUID infusion immediately and institute appropriate treatment.

RENAL DYSFUNCTION/FAILURE: Monitor renal function, including blood urea nitrogen, serum creatinine, and urine output in patients at risk of acute renal failure. Ensure that patients with pre-existing renal insufficiency are not volume depleted. For patients at risk for renal dysfunction or thrombotic events, administer GAMMAGARD LIQUID at the minimum infusion rate practicable.

Hyperproteinemia, increased serum viscosity, and hyponatremia may occur in patients receiving GAMMAGARD LIQUID.

THROMBOSIS: Thrombosis may occur following treatment with immune globulin products, including GAMMAGARD LIQUID. Monitor for signs and symptoms of thrombosis and assess blood viscosity in patients at risk for hyperviscosity.

Aseptic Meningitis Syndrome (AMS) may occur with IGIV treatment, and has been reported with intravenous (IV) use of GAMMAGARD LIQUID. AMS may occur more frequently with high dose (2 g/kg) IGIV treatment and/or rapid infusion of IGIV.

Hemolytic anemia can develop subsequent to GAMMAGARD LIQUID treatment due to enhanced RBC sequestration. Risk factors may include: high doses (e.g., ≥2 g/kg cumulative dose), non-O blood group, and underlying inflammation. Monitor patients for clinical signs and symptoms of hemolysis and delayed hemolytic anemia.

Transfusion-Related Acute Lung Injury (TRALI): Non-cardiogenic pulmonary edema has been reported in patients following treatment with IGIV products, including GAMMAGARD LIQUID. Monitor patients for pulmonary adverse reactions.

GAMMAGARD LIQUID is made from human blood. It may carry a risk of transmitting infectious agents, e.g., viruses, the variant Creutzfeldt-Jakob disease (vCJD) agent, and theoretically, the Creutzfeldt-Jakob disease agent. No confirmed cases of viral transmission or vCJD have been associated with GAMMAGARD LIQUID.

Passive transfer of antibodies may transiently impair the immune responses to live attenuated virus vaccines such as mumps, rubella, varicella, and measles. This passive transfer may also yield false positive serological testing results, with the potential for misleading interpretation.

ADVERSE REACTIONS

The serious adverse reactions in the MMN (IV administration) clinical trial were pulmonary embolism and blurred vision. The most common adverse reactions observed in ≥ 5% of patients in the clinical trials were:

> MMN (IV administration): Headache, chest discomfort, muscle spasms, muscular weakness, nausea, oropharyngeal pain, and pain in extremity.

Please see the accompanying full Prescribing Information, including Boxed Warning.

This form is designed to facilitate the compliance of HIPAA as well as other privacy laws.

Reference: 1. GAMMAGARD LIQUID [Immune Globulin Infusion (Human)] 10% [package insert]. Westlake Village, CA: Baxter Healthcare Corporation

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