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

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 ☐ Co-Pay Card ☐ 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 CODES:** *LIST PRINCIPAL DIAGNOSIS FIRST* _____

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

ROUTE OF ADMINISTRATION:

☐ **Subcutaneous administration (SCIG)**—For primary immunodeficiency (PI) patients switching from intravenous (IVIG) to subcutaneous treatment, the formula (right) is used to calculate the recommended initial dose.[1]

☐ **Intravenous administration (IVIG)**—For PI patients, intravenous immunoglobulin doses of 300 to 600 mg/kg every 3 to 4 weeks based on clinical response.[1]

SCIG DOSE = (1.37 X PREVIOUS IVIG DOSE) / (# OF WEEKS BETWEEN IVIG DOSES)

PATIENT WEIGHT: _____ ORDERED DOSE: _____ GRAMS _____ mg/kg/DOSE FREQUENCY: _____

ROUTE: ☐ Central IV ☐ Peripheral IV ☐ SC: Needle length, mm: _____ REFILLS: _____ times (as allowed by state or payor requirement)

OTHER MEDICATIONS: _____ DRUG ALLERGIES: _____

Additional services

☐ Provide needles, syringes, Venous Access Device (VAD) supplies & other ancillary supplies needed for infusion

☐ Durable Medical Equipment (DME)—Infusion pump with supplies

☐ Anaphylaxis kit: _____

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 replacement therapy for primary humoral immunodeficiency (PI) in adult and pediatric patients two years of age or older. This includes, but is not limited to, common variable immunodeficiency (CVID), X-linked agammaglobulinemia, congenital agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies.

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 reaction that occurred during the PI (IV administration) clinical trials was aseptic meningitis. No serious adverse reactions were observed during the PI subcutaneous (SC) administration clinical trial. The most common adverse reactions observed in ≥ 5% of patients in clinical trials were:

PI (IV administration): Headache, fatigue, pyrexia, nausea, chills, rigors, pain in extremity, diarrhea, migraine, dizziness, vomiting, cough, urticaria, asthma, pharyngolaryngeal pain, rash, arthralgia, myalgia, oedema peripheral, pruritus, and cardiac murmur.

PI (SC administration): Infusion site (local) event, headache, fatigue, heart rate increased, pyrexia, abdominal pain upper, nausea, vomiting, asthma, blood pressure systolic increased, diarrhea, ear pain, aphthous stomatitis, migraine, oropharyngeal pain, and pain in extremity.

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

The information you provide will be used to administer support services and information on Baxter's programs, therapies and services to you and your patient. We may share the information provided with our partners who facilitate the verification and delivery of this information. If you ever decide that you do not wish to receive information from us regarding our therapies and services, contact us at: Consumer Relations, Baxter Healthcare Corporation, One Baxter Parkway, Deerfield, IL 60015 or at 800-241-9360. If you have any questions, comments, concerns, or complaints about our information practices, call 1-800-422-9837 (U.S.) or 847-948-4770 (outside of the U.S.), fax your inquiry to 847-948-3642, or send us mail at Center for One Baxter, One Baxter Parkway, Deerfield, IL 60015.

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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