Immune Globulin Order Form

Please fax all pages with a copy of medical history and recent labs to (888) 388-1309**

For Inquiries call: **Georgia** prescribers line: **(844) 803-2220** **All other** prescribers:**(844) 598-2557**

Patient Information

Date of Birth:	Patient name:	☐ Male ☐ Female
Requested Start of Care Date:	Height:	Weight (kg):
Address:	City: State:	Zip:
Allergies:		
Other Medications:		
Primary Diagnosis:		ICD-10:
Insurance: ☐ Front and back of insurance cards attached	**Medical History**: ☐ Clinical Notes and labs attached	

Immune Globulin Order

IV Access: ☐ Peripheral ☐ Port ☐ PICC Line ☐ Other:_____

Immune Globulin: ☐ No Preference (Pharmacist to determine appropriate product based on clinical risk assessment, insurance, and availability)

☐ Preferred Product :_____ _____

Directions: ☐ Infuse IV ☐ Infuse SC

☐ Loading Dose: _____ gm/kg divided over _____ days every ____week/s OR ____ gm/day x ____day/s every ____week/s

☐ Maintenance: _____ gm/kg divided over _____ days every ____week/s OR ____ gm/day x ____day/s every ____week/s

☐ Other:_____

QTY: _____ Gm X 1 month supply refill for one year unless otherwise noted **Other**:_____

Premedication Orders / Other Orders- Dispense PRN X 1 year

Drug	Patient's type	Description / Dispense Quantity Sufficient	Dose	Route / Frequency
☐ **ACETAMINOPHEN**	Adult & Pediatric ≥12 years (if not at least 95 lb., follow <12 years dosing)	325 mg tab OR 160 mg/5 ml Oral 120 ml	325 - 650 mg	PO pre-lg prn. May repeat q 4 - 6 hours prn. Max 3 gm/day.
	Pediatric 0 - 11 years	160 mg/5 ml Oral 120 ml	10 mg/kg (round to nearest 1/4 tsp)	PO pre-lg prn. May repeat q 4 - 6 hours prn. Max 50 mg/kg/day.
☐ **DIPHENHYDRAMINE**	Adult	25 mg tab OR 12.5 mg/5 ml Oral 120 ml	25 - 50 mg	PO pre-lg prn. May repeat q 4 - 6 hours prn.
	Pediatric > 12 years		25 mg	
	Pediatric 6 - 11 years	12.5 mg/5 ml Oral 120 ml	12.5 - 25 mg	
	Pediatric 2 - 5 years	12.5 mg/5 ml Oral 120 ml	6.25 mg	

☐ **Hydration: _____ Sol ____ mL**

☐ **Solu-Cortef _____ mg**

☐ **Solu-Medrol _____ mg**

☐ **Other_____**

☐ **Other_____**

Directions:

Nursing Order

RN to complete assessment and administer IVIG via ambulatory pump or teach SCIG self-administration via syringe pump.
RN to insert peripheral IV or access central venous catheter.
RN to flush IV post infusion

Ancillary Supplies and DME Orders (Dispense quantity sufficient)

Ancillary supplies, including a disposable IV pole, for the infusion of IVIG via peripheral IV, port, or indwelling central catheter via gravity or by ambulatory infusion pump For Medicare B: services, supplies & accessories used in the home, per infusion (Q2052).

SandsRx Pharmacy

Fax all pages to (888) 388-1309

Patient Name: _____ **Date of Birth:**_____

☐ Anaphylaxis Orders- Dispense PRN x 1 year

Drug	Patient Type	Dose	Dispense Detail	Route/Frequency	Reaction Severity
DIPHENHYDRAMINE (Oral)	Adult & Pediatric >30 kg	50 mg	25 mg tab #4 or 12.5 mg/5 ml oral 120 ml	Administer 50 mg PO x1. May repeat once if symptoms persist.	**Mild** RN to slow infusion rate by 50% until symptoms resolve
	Pediatric 15-30 kg	25 mg	12.5 mg/5 ml oral 120 ml	Administer 25 mg PO x1. May repeat once if symptoms persist.	
	Pediatric <15 kg	12.5 mg		Administer 12.5 mg PO x1. May repeat once if symptoms persist.	
DIPHENHYDRAMINE (IM/IV)	Adult & Pediatric >30 kg	50 mg	50mg vial for injection #1	Administer 50 mg slow IV push at rate not to exceed 25mg/minute	**Moderate-Severe** moderate symptoms, resume at 50% previous rate IF symptoms resolve.
	Pediatric 15-30 kg	25 mg		Administer 25 mg slow IV push at rate not to exceed 25mg/minute	
	Pediatric <15 kg	12.5 mg		Administer 12.5 mg slow IV push at rate not to exceed 25mg/minute	
Epinephrine (IM)	Adult & Pediatric >30 kg	0.3 mg	**SCIG**: 0.3mgAutoInjector #2 **IVIG**: 1 mg/ml 1 m vial/amp #2	Inject 0.3 mg IM (auto-injector) or SubQ (vial/amp) x 1 dose. May repeat in 5 – 15 minutes as needed	**Severe** Activate 911.Administer CPR if needed until EMS arrives. Contact prescriber to communicate patient status
	Pediatric 15-30 kg	0.15 mg	**SCIG**: 0.15mg Auto-Injector #2 **IVIG**: 1 mg/ml 1 m vial/amp #2	Inject 0.15 mg IM (auto-injector) or SubQ (vial/amp) x 1 dose. May repeat in 5 – 15 minutes as needed.	
	Pediatric <15 kg	0.01mg/kg	1 mg/ml 1 ml vial/amp #2	SC x 1 dose. May repeat in 5 – 15 minutes as needed.	
Sod. chloride 0.9%	Adult and Pediatric	500 mL	500 ml IV Bag #1	Stop Causative drug, then administer IV at KVO rate	**Severe**

*Mild allergic reactions include itching, hives, rash, nausea and/or vomiting
*Moderate reaction include chest tightness, shortness of breath, >20 mmHg change in systolic blood pressure from baseline, and/or increase in temperature (>2°F).
*Severe anaphylaxis reactions include angioedema, wheezing, difficulty breathing, swelling of eyelids or lips

IV Access Maintenance- Dispense quantity sufficient PRN X 1

Venous Access	Patient Type	NS 10 ml syringe pre/post use	Heparin 5 ml syringe post last NS	Other
Peripheral	Adult/Pedi > 15 kg	5-10 ml	10 units/ml: 3-5 ml	
	Pedi < 15 kg	1 - 3 ml	10 units/ml: 1-3 ml[b]	
Midline, Central (non-port), PICC[a]	Adult/Pedi > 15 kg	5 ml	10 units/ml: 3 - 5 ml[b]	
	Pedi ≤ 15 kg	3 ml	10 units/ml: 3 ml[b]	
Implanted Port[a]	Adult/Pedi > 15 kg	5 - 10 ml	100 units/ml: 5 ml[c]	
	Pedi < 15 kg	3 ml	100 units/ml: 3 ml[c]	
Groshong PICC/Midline[a]	Adult/Pedi > 15 kg	5 - 10 ml[d]	None	
	Pedi < 15 kg	3 - 5 ml[d]	None	

(a) Follow manufacturer-specific recommendations if different. Maintenance flush when not in use: [b]daily, [c]daily if accessed; monthly if de-accessed, [d]daily to weekly

Physician Information

Name:_____ **Practice:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Phone:_____ **Fax:**_____ **NPI:**_____ **Contact:**_____

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy.

_____ **Substitution permissible signature**

_____ **Dispense as written signature**

_____ **Date**