



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:	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Phone Number:	Height:	Weight (kg):	
Address:	City:	State:	Zip:
Allergies:		Requested Start of Care Date:	
Other Medications:			
Primary Diagnosis:		ICD-10:	
Insurance: <input type="checkbox"/> Front and back of insurance cards attached		Medical History: <input type="checkbox"/> Clinical Notes and labs attached	

Immune Globulin Order				
IV Access: <input type="checkbox"/> Peripheral <input type="checkbox"/> Port <input type="checkbox"/> PICC Line <input type="checkbox"/> Other: _____				
Immune Globulin: <input type="checkbox"/> No Preference (Pharmacist to determine appropriate product based on clinical risk assessment, insurance, and availability)				
<input type="checkbox"/> Preferred Product: _____				
	Dose		Frequency	Route
	Weight based	OR	Fixed	
<input type="checkbox"/> Loading Dose	<input type="checkbox"/> _____ grams/kg over ___ day(s)		<input type="checkbox"/> _____ grams over ___ day(s)	Every _____ week(s)
<input type="checkbox"/> Maintenance	<input type="checkbox"/> _____ grams/kg over ___ day(s)		<input type="checkbox"/> _____ grams over ___ day(s)	Every _____ week(s)
	<input type="checkbox"/> Convert to SubQ dose			
<input type="checkbox"/> Other				

Dispense quantity sufficient and refill for one year unless otherwise noted Other: _____

Premedication Orders / Other Orders- Dispense PRN X 1 year				
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Drug	Patient's type	Description / Dispense Quantity Sufficient	Dose	Route / Frequency
<input type="checkbox"/> 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-Ig 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-Ig prn. May repeat q 4 - 6 hours prn. Max 50 mg/kg/day.
<input type="checkbox"/> DIPHENHYDRAMINE	Adult	25 mg tab OR	25 - 50 mg	PO pre-Ig prn. May repeat q 4 - 6 hours prn.
	Pediatric > 12 years	12.5 mg/5 ml Oral 120 ml	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	

<input type="checkbox"/> Hydration: _____ Sol _____ mL <input type="checkbox"/> Solu-Cortef _____ mg <input type="checkbox"/> Solu-Medrol _____ mg <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____	Directions: <hr/> <hr/> <hr/> <hr/>
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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).



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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: 0.3mg Autoinjector #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: ^bdaily, ^cdaily if accessed; monthly if de-accessed, ^ddaily to weekly

Physician Information

Name: _____ Practice: _____ Tax ID: _____
 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