

✂ Please detach before submitting to a pharmacy – tear here.

PATIENT INFORMATION

IG specialist	Name: _____		Primary diagnosis:
	Phone: _____		
Patient	<input type="checkbox"/> see attached	Gender: <input type="radio"/> Male <input type="radio"/> Female	<input type="checkbox"/> Combined immunodeficiency <input type="checkbox"/> Common hypogammaglobulinemia <input type="checkbox"/> Common variable immunodeficiency <input type="checkbox"/> Immune thrombocytopenic purpura <input type="checkbox"/> Immunodeficiency with increased IgM <input type="checkbox"/> Wiskott-Aldrich syndrome <input type="checkbox"/> Other: _____
Patient name: _____			
DOB: _____ SSN: _____			
Address: _____			
City: _____ State: _____ Zip: _____			
Phone: _____ Cell: _____			
Emergency contact: _____			
Phone: _____ Relationship: _____			
Insurance	<input type="checkbox"/> Front and back of insurance card to follow		
	Primary	Secondary	
Insurance:			
Phone:			
Policy #:			
Group:			
Medical assessment			
Height: _____ Weight: _____ <input type="radio"/> lbs <input type="radio"/> kg			
Current medications? <input type="radio"/> Yes <input type="radio"/> No			
If yes, list or attach: _____			
Allergies: _____			

PRESCRIPTION ORDERS

Immune Globulin:	Initial: _____ gm/kg divided over _____ days			
<input type="checkbox"/> No preference	Ongoing: _____ gm/kg divided over _____ days			
<input type="checkbox"/> Preferred product: _____	every _____ weeks for _____ cycles			
Directions:	Quantity/Refills:			
<input type="checkbox"/> Infuse IV <input type="checkbox"/> Infuse SC	<input type="checkbox"/> 1-month supply; refill x 12 months unless otherwise noted			
<input checked="" type="checkbox"/> Per manufacturer guidelines or as written below:	<input type="checkbox"/> Other: _____			
<input checked="" type="checkbox"/> May round to the nearest 5gm vial size	<input checked="" type="checkbox"/> Infusion reaction management and kit order			
Pre-medications 30 minutes before start of IG:	Mild	Slow infusion rate by 50% until symptoms resolve Diphenhydramine PO <input type="radio"/> 25 mg <input type="radio"/> 50 mg <input type="checkbox"/> other: _____		
<input type="checkbox"/> Acetaminophen PO <input type="radio"/> 325 mg <input type="radio"/> 500 mg <input type="radio"/> 650 mg	Moderate	Stop infusion, resume at 50% when symptoms resolve Diphenhydramine IV <input type="radio"/> 25 mg <input type="radio"/> 50 mg <input type="checkbox"/> other: _____		
<input type="checkbox"/> Diphenhydramine PO <input type="radio"/> 25 mg <input type="radio"/> 50 mg	Severe (Anaphylaxis) *Call 911*	Stop infusion; initiate 0.9% NaCl 500 mL IV Administer epinephrine 1 mg/mL by weight (Wt):		
<input type="checkbox"/> Hydration, solution: _____ Volume _____ mL		Wt > 66 lbs (30 kg) = 0.3 mg/.3mL	Wt 33 - 66 lbs (15 - 30 kg) = 0.15 mg/0.15mL	Wt < 33 lbs (<15 kg) = 0.01 mg/kg
<input type="checkbox"/> Other: _____		Repeat epinephrine in 5-15 min if symptoms continue. Administer CPR if needed until EMS arrives.		
Nursing and other orders:				
<input checked="" type="checkbox"/> Administer IVIG or teach SCIG self-administration, via pump				
<input checked="" type="checkbox"/> Ambulatory pump if required for infusion				
<input checked="" type="checkbox"/> Initiate access device (insert peripheral IV, SC needles, access implanted port, or use existing PICC)				
<input checked="" type="checkbox"/> Flush PIV with 5mL NS (for other orders, contact physician)				
<input type="checkbox"/> Obtain labs (list): _____				
Lab frequency: <input type="checkbox"/> Once <input type="checkbox"/> Monthly <input type="checkbox"/> Other: _____				

PHYSICIAN INFORMATION

Name: _____	Address: _____		
Practice: _____	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. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.			
Substitution permissible Signature: _____		Date: _____	Dispense as written Signature: _____