Immunoglobulin Order Form

INFUSE Rx

PATIENT INFORMATION

Referral Status: □ New Referral □ Updated Order □ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

□ NKDA Allergies: Weight (kg): Height:

Patient Status: □ New to Therapy □ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

□ Provide nursing care per facility Nursing Procedures, including reaction management and post-procedure observation

PRE-MEDICATION ORDERS

□ acetaminophen (Tylenol) □ 500mg / □ 650mg / □ 1000mg PO
□ cetirizine (Zyrtec) 10mg PO
□ loratadine (Claritin) 10mg PO
□ diphenhydramine (Benadryl) □ 25mg / □ 50mg □ PO / □ IV
□ methylprednisolone (Solu-Medrol) □ 40mg / □ 125mg IV
□ Normal Saline 500mL IV Bolus
□ Other: _____

Dose: _____ Route: _____ Frequency: _____

LABORATORY ORDERS

All initial or baseline labs/imaging must be drawn/performed and reviewed by the referring provider prior to submitting a new infusion order. Infusion center will only draw maintenance labs as indicated below:

□ Lab: _____ □ Frequency: _____
□ Lab: _____ □ Frequency: _____
□ Lab: _____ □ Frequency: _____

THERAPY ADMINISTRATION

□ Infuse IV Immunoglobulin with brand selection determined by the pharmacist based on clinical indication, insurance coverage and product availability

□ Infuse this specific immunoglobulin brand (subject to prior authorizations:

_____

□ ***Loading dose:***
  □ _____ grams OR _____ gm/kg
  □ Administered as a onetime dose
  □ Divide dose over _____ days
  □ Start maintenance dose _____ weeks after loading dose

□ ***Maintenance dose:***
  □ _____ grams OR _____gm/kg
  □ Administer as a single dose
  □ Divide over _____ days
  □ Frequency: every _____ weeks

□ ***Administration:*** Round dose to the nearest whole 5 gram vial
  □ Infuse at a rate of 0.01 mL/kg/min, increasing every 15-30 minutes to 0.02 mL/kg/min, 0.04 mL/kg/min, 0.06 mL/kg/min then 0.08 mL/kg/min as tolerated.

□ Refills: □ Zero / □ for 12 months / □ _____
(if not indicated order will expire one year from date signed)

Provider Name (Print) Provider Signature Date

Special Instructions