Immune Globulin Prescription Form

Patient Information

Patient Name: Date of Birth: Gender: ☐ Male ☐ Female

Address: Phone #:

Height (in/cm) Weight: (lbs/kg) Date: Allergies:

Therapy Status: ☐ First Dose ☐ Continuation of Therapy Previous products used:

Medical Information – Primary Diagnosis – ICD - 10

ICD-10 Code: ICD-10 Description:

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Rx Information: Pharmacist to identify clinically appropriate Ig brand and rate per PI guidelines. Clinically appropriate substitutions allowed based on availability or payor requirements. IV and SC dose rounded to the nearest vial size. May infuse +/- 4 days per patient schedule requests.

Route: ☐ IV ☐ SubQ | Access: ☐ IV ☐ PICC ☐ Port

Loading Dose: __________ gm/kg daily for__________ day(s)

Maintenance Dose: _________ gm/kg daily for____________day(s) every__________ week(s)

Other: ____

Refill: ______________

Ancillary Orders

Pre-Medication: ☐ Dispense QS | Refill: ___________________________________

☐ Acetaminophen 325 mg-650mg PO 30 min before infusion.

☐ Diphenhydramine 25-50mg mg PO 30 min before infusion.

☐ Other: ____

☐ Other: ____

IV Flush Orders: ☐ Dispense QS | Refill ________________

☐ Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use. ☐ Heparin (10 unit/mL) 1 to 3 mL post-use.

☐ Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use Heparin (100 unit/mL) 3 to 5 mL post-use.

Anaphylaxis Orders

☐ IV Doses:

- Epinephrine 0.3 mg SubQ or IM x 1 dose & repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg IV and IM; may repeat x 1 dose in 15 min PRN if no improvement.
- 0.9% Sodium Chloride 10 mL IV Flush. Flush line with 5mL to 10mL PRN anaphylaxis
- 0.9% Sodium Chloride 500 mL IV at infusion rate PRN anaphylaxis

☐ SUBQ Doses: Epinephrine Auto-Injector 0.3 mg 2-Pack Kit – Inject 0.3 mg IM x 1 dose PRN anaphylactic reaction, repeat x 1 PRN.

Ancillary Supplies

Dispense ancillary supplies and equipment (including pump and pole) needed to provide home infusion therapy

Nursing Orders for Home Infusion (IV only)

Frequency of vital signs monitoring: If initial infusion or more than 8 weeks since last infusion: Prior to infusion,q 15 minutes for the first hour,q 30 minutes during the second hour,q 1 hour for the remainder of the infusion. If subsequent infusion within 8 weeks: Prior to infusion,q 15 minutes for the first hour, q 1 hour for the remainder of the infusion

SubQ IG Teaching Needs: ☐ Patient Independent ☐ Patient Teaching Needed

Prescriber Information

Prescriber name: NPI:

Address:

Phone: Fax: Office Contact:

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber's Signature: ____ Date: ____________________________________

Product Selection Permitted

Prescriber's Signature: Date:

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