

# IMMUNE GLOBULIN (ADULT) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:



Patient Name:

Date of Birth:

Address:

Phone:

Height:

inches  cm

Weight:

lbs  kg

## Clinical Information

Primary Diagnosis Description:

ICD-10 Code:

Is this the first dose?

Yes  No – date of last dose:

## Immune Globulin Prescription

Immune globulin refill as directed x 1 year

Loading Dose:  \_\_\_\_\_

Maintenance Dose:  IV  Subcutaneous

Infuse \_\_\_\_\_ gm for \_\_\_\_\_ day(s) every \_\_\_\_\_ week(s)

Infuse \_\_\_\_\_ gm/kg (BMI > 30, adjusted body weight used) divided over \_\_\_\_\_ day(s) every \_\_\_\_\_ week(s)

Other: \_\_\_\_\_

Pharmacist to identify clinically appropriate IG brand and infusion rates. May substitute product based on product availability.

Infuse entire contents of IG infusion bag/vial(s) per current dose.

Round dose to nearest whole 5 gm vial for IV doses and nearest single-use vial size for subcutaneous doses.

May infuse +/- 4 days to allow for patient scheduling.

## Ancillary Orders

### Anaphylaxis Orders

➔ IV Doses: Please complete Anaphylaxis Physician Order (FR-PC-036) provided – required per Option Care Health policy.

SQ Doses: Epinephrine Auto-Injector 0.3 mg 2-Pack Kit – Inject 0.3 mg IM x 1 dose PRN anaphylactic reaction, repeat x1 PRN.

### Pre-Medication Orders

Acetaminophen \_\_\_\_\_ mg PO 30 min before infusion. Patient may use own supply or patient may decline.

Diphenhydramine \_\_\_\_\_ mg PO 30 min before infusion. Patient may use own supply or patient may decline.

Other: \_\_\_\_\_

Other: \_\_\_\_\_

Other: \_\_\_\_\_

### IV Flush Orders

Peripheral: NS 2 to 3 mL pre-/post-use. Heparin (10 unit/mL) 1 to 3 mL post-use.

Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Skilled nurse to administer doses intravenously where applicable. Skilled nurse to assess and teach self-administration of SQ medication where appropriate. Nurse will provide ongoing support, including administration of medication, PRN. Refill above ancillary orders as directed x 1 year.

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

Prescriber Signature:

Date:

## Prescriber Information

Prescriber Name:

Phone:

Fax:

Address:

NPI:

City, State:

Zip:

Office Contact:

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