IMMUNE GLOBULIN MATERNAL FETAL MEDICINE 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 next dose due:	
Current gestational age:	**EDC:**	**G/P:**

Immune Globulin Prescription

Immune globulin refill as directed x 1 year

☐ Infuse ________ gm IV for _____ day(s) every _____ week(s)

☐ Infuse ________ gm/kg IV 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.
May infuse +/– 4 days to allow for patient scheduling.

Ancillary Orders

Anaphylaxis Kit

➔ Required per Option Care Health policy – please complete Anaphylaxis Physician Order (FR-PC-036) provided.

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.

☐ Methylprednisolone ________ mg IV 30 min before infusion.

☐ Prednisone ________ mg PO 30 min before infusion.

☐ 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. 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:**	

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. **IMPORTANT WARNING**: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.

 @2020 UBACARE. All Rights Reserved.