IMMUNE GLOBULIN (PEDIATRICS) PRESCRIBER ORDER FORM

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

YOUR INTELLIGENT HEALTH COMPANY.
UBACARE

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 the nearest single-use vial size.
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 (≥ 30 kg) or 0.15 mg (15 to 30 kg) 2-Pack – Inject 1 dose IM x 1 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 1 mL (2 to 20 kg) or 1 to 3 mL (> 20 kg) pre-/post-use and 1 to 3 mL (2 to 20 kg) or 3 to 5 mL (> 20 kg) pre-/post-lab draw. Heparin (10 unit/mL) 1 mL (2 to 20 kg) or 1 to 3 mL (> 20 kg) post-use.

☐ Implanted Port: NS 1 to 3 mL pre-/post-use and 3 to 5 mL pre-/post-lab draw. Heparin (10 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (10 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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