

IMMUNE GLOBULIN – TRANSPLANT (PEDIATRICS) PRESCRIBER ORDER FORM

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



Patient Name:		Date of Birth:		
Address:				
Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg

Clinical Information

Applicable Diagnosis:

- | | |
|---|--|
| <input type="checkbox"/> Kidney Transplant – Z94.0 | <input type="checkbox"/> Complications of Heart Transplant – T86.2 |
| <input type="checkbox"/> Complications of Kidney Transplant – T86.1 | <input type="checkbox"/> Lung Transplant – Z94.2 |
| <input type="checkbox"/> Liver Transplant – Z94.4 | <input type="checkbox"/> Complications of Lung Transplant – T86.81 |
| <input type="checkbox"/> Complications of Liver Transplant – T86.4 | <input type="checkbox"/> Complications of Bone Marrow Transplant – T86.0 |
| <input type="checkbox"/> Heart Transplant – Z94.1 | |
| <input type="checkbox"/> Other: _____ | |

Is this the first dose? Yes No – date of next dose due: _____

Immune Globulin Prescription

Immune globulin refill as directed x 1 year

- Infuse _____ gm IV for _____ day(s) every _____ week(s)
- Infuse _____ gm/kg (max _____ gm/course) 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 single-use 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.
- 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. 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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