IMMUNE GLOBULIN – TRANSPLANT (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

Applicable Diagnosis:

- ☐ Kidney Transplant – Z94.0
- ☐ Complications of Kidney Transplant – T86.1
- ☐ Liver Transplant – Z94.4
- ☐ Complications of Liver Transplant – T86.4
- ☐ Heart Transplant – Z94.1
- ☐ Complications of Heart Transplant – T86.2
- ☐ Lung Transplant – Z94.2
- ☐ Complications of Lung Transplant – T86.81
- ☐ Complications of Bone Marrow Transplant – T86.0

☐ 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:**	

