

MRN: \_\_\_\_\_

**Palmetto Infusion Services  
Standard IVIG Plan of Treatment**

(Re)Certification Period From \_\_\_\_\_ to \_\_\_\_\_

**Note:** We require MD office notes and may require a letter of Medical Necessity (depending on diagnosis), to be able to verify eligibility and payment for this treatment through patients Medicare and/or other insurance plan.

**Patient's Name** \_\_\_\_\_ **Ht:** \_\_\_\_\_ **Wt:** \_\_\_\_\_ **Allergies:** \_\_\_\_\_

**Primary Diagnosis** \_\_\_\_\_ **Secondary Diagnosis:** \_\_\_\_\_

**Physician Office to Complete:**

**1. Has your patient had failure, intolerance, or contraindication to conventional therapy?**

Yes                       No

**2. If yes, please specify, treatment/medication tried and outcomes:** \_\_\_\_\_

**ORDERS:**

Premedicate with (Check all that Apply):  None OR 30 Minutes prior to infusion:

Acetaminophen 650 mg PO or \_\_\_\_\_ mg PO  Diphenhydramine 50 mg PO or \_\_\_\_\_ mg IVP

OR  Premedicate with other: \_\_\_\_\_

OR: Prescriptions for the following pre-meds were sent home with the patient, for him/her to take prior to each clinic visit: \_\_\_\_\_

Obtain weight each visit. Vital Signs baseline then every 15 mins X 1 hr, then every 30 mins until complete, for the first 3 treatments, after 3<sup>rd</sup> infusion baseline then every 30 mins for duration of infusion.

Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient response to therapy. Pump, tubing, and supplies needed to complete prescribed therapy.

Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn Normal Saline Flush 3-10 ml before infusion, after primary drug has infused, Infuse Normal Saline 0.9% 20-50 ml to flush tubing/line, followed by Heparin Lock 1-5ml 100 units/ml as needed per line type.

**If adverse drug reaction, Implement the Standing Adverse Reaction protocol.**

**Drug:** \_\_\_\_\_

**\*\* CHF/NA+ restricted/Diabetic patients may require an alternate IVIG preparation\*\***

**Dose:** \_\_\_\_\_ Gms OR \_\_\_\_\_ Mg/kg over \_\_\_\_\_ hours via pump. Every \_\_\_\_\_ weeks.

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

**Labwork: (For immunodeficiency patients only)**

IGG trough to be drawn every 3 months

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

Pharmacist to perform clinical drug monitoring.

**NOTE: DO NOT ADMINISTER IVIG IF PATIENTS TEMPERATURE IS GREATER THAN OR EQUAL TO 101.5 ORALLY AND NOTIFY MD.**

**NO STAMPED SIGNATURES PLEASE**

Physician's Signature: \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_

(Dispense as written)

(Substitution permitted)

**PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO:  
TOLL FREE FAX (866) 872-8920**