**Standard IVIG for CIDP 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:** CIDP

**Secondary Diagnosis:**

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### 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: _____________________________

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### ORDERS:

Premedicate with (Check all that Apply):

- □ None
- □ 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 3rd 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:** IVIG: Infuse- Gammaked or Gamunex-C

**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.

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**NO STAMPED SIGNATURES PLEASE**

Physician’s Signature: ___________________________/ ___________________________ Date: ________

(Dispense as written) (Substitution permitted)

Print Physician Name: _____________________________

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**PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO:**

866-872-8920