Palmetto Infusion Services

MRN:_____

Phone: 800-809-1265

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: _____

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 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 immunodefficiency 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)

Print Physician Name:_____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO:
866-872-8920