Palmetto INFUSION

MRN:_____

Phone: 1-800-809-1265 Fax: 1-866-872-8920

DOB:_____

STANDARD Intravenous Immune globulin (IVIG) PLAN OF TREATMENT

NOTE: We require MD office notes to support clinical treatment and may require a Letter of Medical Necessity (depending on diagnosis), to be able to verify eligibility and payment for this treatment through patient Medicare and/or other insurance plan.

1. Patient Name: _____Height (inches): _____Weight (lbs):_____

2. Allergies: _____

3. Diagnosis: *** Please complete the 2nd and 3rd digits to complete the ICD-10 code for billing**

☐ D80. ____ **Hypogammaglobulinemia** or Select IG Deficiency ☐ D83.____ **Common variable immune deficiency**
☐ G61.81 **CIDP** ☐ M33.9___ **Dermatopolymyositis** ☐ M33.2___ **Polymyositis** ☐ G61.0 **Guillain-Barre syndrome**
☐ **Myasthenia Gravis:** ☐ G70.01 **with acute exacerbation**, ☐ G70.00 **without acute exacerbation** ☐ D69.3 **ITP**
☐ **Other** *ICD-10 Code* (Diagnosis/Description):_____

4. Pre-medications: ☐ None ***OR*** ***Administered 30 minutes prior to infusion as selected:***

Acetaminophen:	Diphenhydramine: ☐ 25 mgs PO, ☐ 50mgs PO, ☐ 25 mgs IVP, ☐ 50mgs IVP or
☐ 1000 mgs PO	Alternate oral antihistamine to diphenhydramine:
☐ 650mgs PO	☐ Cetirizine 10 mg, ☐ Loratadine 10 mg, Fexofenadine ☐ 60mgs or ☐ 180mgs
☐ 500mgs PO	Methylprednisolone ☐ 40mgs IVP ☐ 125mgs IVP or other _____mgs IVP
☐ 325mgs PO	Famotidine: ☐ 20mgs PO, ☐ 40mgs PO, ☐ 20mgs IVP, ☐ 40mgs IVP

Pre-medicate with other: _____

Refer to IVIG prescribing guidelines: IVIG product brand will be based on supply, availability of product, and/or most cost effective IVIG product; unless specified. Infusion rate protocol: will be based on consideration of age, medical history, risk of renal failure, and patient tolerance. Ideal Body Weight (IBW) may be used to dose IVIG and dose may be rounded to the nearest vial to minimalize product waste.

5. Dose: Intravenous Immune Globulin (IVIG) _____ gm per dose or _____ gm/kg/day over _____ day(s) IV infused per protocol or over _____ hours as specified via pump with 1.2 micron filter

6. Frequency: ☐ Once ☐ Every ____ weeks ☐ Other: _____

Special orders:_____

☐ Dose IVIG on Actual Body Weight ☐ Specific brand of IVIG required: _____

Clinical lab monitoring: IgG trough will be drawn every 3 months prior to infusion (for immunodeficiency patients only)

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

IVIG will not be administered if patient temperature greater than 101.5 orally and MD office will be notified.

7. Physician's Signature: _____/ _____Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: _____NPI: _____

8. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms and Adverse Drug Reaction Guidelines are available at www.palmettoinfusion.com

Revised 6/21/18

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DOB:_____

Guidelines for Prescribing Intravenous Immune globulin (IVIG) PLAN OF TREATMENT

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:**_____

☐ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-8)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

IVIG dosing guidelines:

- IVIG product brand will be based on supply, availability of product, and/or most cost effective IVIG product. MD does not need to specify brand on order, unless clinically indicated.
- IVIG dosing will be rounded to the nearest 5 gm vial for adults and 1 gm vial for pediatric patients to minimize product waste.
- Ideal Body Weight (IBW) may be used to dose IVIG. Adjusted Body Weight will be used when a patient has an Actual Body Weight (ABW) greater than 130% of IBW.
    a) IBW Males (kg) = 50 + (2.3 x (height in inches – 60))
    b) IBW Females (kg) = 45.5 + (2.3 x (height in inches -60))
    c) If height < 60 inches, use 50 kg (male) and 45.5 kg (female) to calculate IBW
    d) Adjusted Body Weight = IBW + 0.4 (Actual Body Weight – IBW)
- Infusion rate per protocol based on consideration of age, medical history, risk of renal failure, and patient tolerance.

Other as requested: _____

Pre-Screening:

☐ IgG level (for immunodeficiency patients only)

☐ BMP level (if available)

** Warnings/Precautions: **Thrombosis**: may occur with immune globulin products. Risk factors may include advanced age, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling vascular catheters, hyper viscosity and cardiovascular risk factors. For patients at risk of thrombosis, administer IVIG at the minimum dose and infusion rate practicable. Ensure adequate hydration in patients before administration. **Renal dysfunction:** acute renal failure, osmotic nephrosis, and death may occur in predisposed patients with immune globulin intravenous (IGIV) products. Renal dysfunction and acute failure occur more commonly with IGIV products containing sucrose. Monitor renal function, including blood urea nitrogen, serum creatinine, and urine output in patients at risk of acute renal failure. Hyperproteinemia, increased serum viscosity and hyponatremia may occur.
Anaphylactic or severe systemic hypersensitivity reactions: IgA deficient patients with antibodies to IgA are at greater risk of developing severe hypersensitivity and anaphylactic reaction. **Aseptic Meningitis Syndrome (AMS)** may occur. **Hemolytic anemia** can develop. Pulmonary Adverse Reactions: may occur, monitor for transfusion-related acute lung injury, TRALI. IVIG is made from human blood, it may carry a risk of transmitting infectious agents, e.g., viruses, the variant Creutzfeldt-Jakob disease (vCJD) agent, and theoretically, the Creutzfeldt-Jakob disease agent. See full prescribing information.

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.