



MRN: _____

DOB: _____

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

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: Administered 30 minutes prior to infusion as selected:

Acetaminophen: <input type="checkbox"/> 1000 mgs PO <input type="checkbox"/> 650mgs PO <input type="checkbox"/> 500mgs PO <input type="checkbox"/> 325mgs PO	Diphenhydramine: <input type="checkbox"/> 25 mgs PO, <input type="checkbox"/> 50mgs PO, <input type="checkbox"/> 25 mgs IVP, <input type="checkbox"/> 50mgs IVP or Alternate oral antihistamine to diphenhydramine: <input type="checkbox"/> Cetirizine 10 mg, <input type="checkbox"/> Loratadine 10 mg, Fexofenadine <input type="checkbox"/> 60mgs or <input type="checkbox"/> 180mgs Methylprednisolone <input type="checkbox"/> 40mgs IVP <input type="checkbox"/> 125mgs IVP or other _____mgs IVP Famotidine: <input type="checkbox"/> 20mgs PO, <input type="checkbox"/> 40mgs PO, <input type="checkbox"/> 20mgs IVP, <input type="checkbox"/> 40mgs IVP
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Pre-medicate with other: _____

Refer to IVIG prescribing guidelines: IVIG product brand will be based on supply and availability of product, unless specified. Infusion rate protocol: will be based on consideration of age, medical history, risk of renal failure, and patient tolerance. **Actual Body Weight (ABW)** will be used to dose IVIG unless otherwise specified.

IVIG: Dose: _____ gm/kg/day _____ gm per day

IVIG dosing will be rounded to the nearest 5 gm vial for adults and 1 gm vial for pediatric patients to minimize product waste.

5. Frequency: Once Daily X _____ doses Every _____ weeks

Special orders: _____

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



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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
- 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 and availability of product. Prescriber 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.
- Actual Body Weight will be used to dose IVIG unless otherwise specified.
- 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.