MRN:_____

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: ***Administered 30 minutes prior to infusion as selected:***

Acetaminophen:
- □ 1000 mgs PO
- □ 650mgs PO
- □ 500mgs PO
- □ 325mgs PO

Diphenhydramine: □ 25 mgs PO, □ 50mgs PO, □ 25 mgs IVP, □ 50mgs IVP or

Alternate oral antihistamine to diphenhydramine:
- □ Cetirizine 10 mg, □ Loratadine 10 mg, Fexofenadine □ 60mgs or □ 180mgs

Methylprednisolone □ 40mgs IVP □ 125mgs IVP or other_____mgs IVP

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 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

5. Frequency: □ Once □ Daily X _____ doses □ Every _____ weeks for _____doses

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: _____

MRN:_____

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**.

☐ 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. 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.
- Actual Body Weight (IBW) will be used to dose IVIG.
- 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.

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center 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.