Palmetto INFUSION®

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

Referral Status:			MRN:
☐ New referral	☐ Order change	☐ Order Renewal	
Patient preferred clinic:			

Intravenous Immune Globulin (IVIG) Unspecified Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:				Patient's Phone:			
Patient Name:				Address:			
Date of Birth:				City, State, Zip:			
Height in inches:	Weight: LB or KG			Gender:	Allergies:	☐ See list	☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	D80._____ - Hypogammaglobulinemia	☐	D83._____ - Common variable immune deficiency
☐	M33.2_____ - Polymyositis	☐	M33.9_____ - Dermatopolymyositis
☐	G61.81 - CIDP	☐	G61.0 - Guillain Barre syndrome
☐	G70.01 - Myasthenia Gravis with acute exacerbation	☐	G70.00 - Myasthenia Gravis without acute exacerbation
☐	D69.3 - ITP	☐	_____- Other:_____

REQUESTED DOCUMENTATION:		PREVIOUS AMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	REQUIRED WASHOUT FROM PREVIOUS THERAPY:	**IF ORDER CHANGE:**
2	H&P including tried and failed therapies		☐ **Continue current order until insurance approved**
3	Full medication list		

[INTERNAL USE ONLY] PHARMACIST CALCULATED DOSE AND INFUSION TIME REVIEW: (IF APPLICABLE)

	Pharmacist initials and date of review:

MEDICATION ORDERS:

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

IV

Diphenhydramine	☐ 25mg	☐ 50mg				
Methylprednisolone	☐ 40mg	☐ 125mg	☐ Other:			
Famotidine	☐ 20mg	☐ 40mg				
Other:	☐					
Prehydration with NS	☐ 250ml	☐ 500ml	☐ 1000ml			
Posthydration with NS	☐ 250ml	☐ 500ml	☐ 1000ml			

Pre and post infusion hydration will be given at 500ml/hour unless stated otherwise here: _____ (maximum 1L/hour)

PO

Acetaminophen	☐ 325mg	☐ 500mg	☐ 650mg	☐ 1000mg
Famotidine	☐ 20mg	☐ 40mg		
Diphenhydramine	☐ 25mg	☐ 50mg		
Fexofenadine	☐ 60mg	☐ 180mg		
Cetirizine	☐ 10mg			
Loratadine	☐ 10mg			
Other:	☐			

INTRAVENOUS IMMUNE GLOBULIN DOSE:

☐ _____gm/kg/day

☐ _____gm/day

Dosing will be rounded to the nearest 5gm for adults and nearest 1gm for pediatric patients to minimize drug waste

FREQUENCY:

☐ One time dose

☐ Daily x _____ days ☐ Once ☐ Every ___ weeks

☐ Once every ____ weeks

☐ Specific Brand of IVIG required:_____

SPECIAL/LAB ORDERS:

☐ _____

_____

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 will be used to dose IVIG unless otherwise specified.

****Dose will be held if patient temperature is > 101.5°F & MD will be notified****

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	