



Fax: 1-866-872-8920

### Intravenous Immune Globulin (IVIG) Unspecified Plan of Treatment

## IN HOME INFUSION

Referral Date:

New referral

Order change

Order Renewal

#### PATIENT DEMOGRAPHICS:

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

#### DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> 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:

#### HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE? Yes or No

1	Insurance information	REQUIRED WASHOUT FROM PREVIOUS THERAPY:	IF ORDER CHANGE: Continue current order until insurance approved
2	H&P including tried and failed therapies		Last Infusion Date:
3	Full medication list		Next Infusion Date:

#### HOME SUPPLY ORDER:

Dispense infusion pump (CADD or Curlin) E0781, IV pole, infusion supplies A4222, tubing, administration set, infusion catheters A4221.

#### Rx MEDICATION ORDERS:

##### PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

IV	Diphenhydramine	25mg	50mg	PO	Acetaminophen	325mg	500mg	650mg	1000mg	
	Methylprednisolone	40mg	125mg		Famotidine	20mg	40mg			
	Famotidine	20mg	40mg		Diphenhydramine	25mg	50mg			
	Other:				Fexofenadine	60mg	180mg			
	Prehydration with NS	250ml	500ml		1000ml	Cetirizine	10mg			
	Posthydration with NS	250ml	500ml		1000ml	Loratadine	10mg			
Pre/post Infusion hydration will be given at 500ml/hour unless stated otherwise here: (maximum 1L/hour)				Other:						

Home Anaphylaxis Kit: Dispense as written and administer for mild and severe reaction.

2 - Epinephrine 1 mg/ml 1 ml  
 2- Diphenhydramine 50 mg/ml 2 ml vial  
 Syringes, needles and 0.9% Normal Saline Flushes 10 mls to administer  
 Complete Home Infusion Physician Standing Order for complete Home Infusion, Nursing, and Adverse Reaction Orders to be utilized in the event of an adverse reaction/anaphylaxis. Epinephrine administered IM per weight based dosing guide and Benadryl 25-50mg IVP to be administered by clinician in the home.

#### INTRAVENOUS IMMUNE GLOBULIN DOSE:

#### FREQUENCY:

<input type="checkbox"/> gm/kg/day	<input type="checkbox"/> One time dose
<input type="checkbox"/> gm/day	Daily x _____ days <input type="checkbox"/> Once <input type="checkbox"/> Every ___ weeks
Dosing will be rounded to the nearest 5gm for adults and nearest 1gm for pediatric patients to minimize drug waste	<input type="checkbox"/> 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:

<input checked="" type="checkbox"/> Start PIV/Access CVC	<b>Dispense and Administer as Prescribed</b>
<input checked="" type="checkbox"/> Flush PIV/Access per PIV/PICC/CVC protocol.	

#### 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
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# IN-HOME INFUSION PHYSICIAN STANDING ORDERS

(CHECK ALL APPLICABLE ORDERS)

Prescriber Office: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Phone: \_\_\_\_\_ Zip: \_\_\_\_\_

## PRESCRIPTION

By signing below, I authorize the administration of flush medications and their associated instructions to our patients. This authorization applies as relevant to the type of access device being utilized. The validity of this order extends for one year from the date of signing.

## SKILLED NURSING

A skilled nurse is authorized to assess, administer, and/or provide self-administration education as appropriate. The nurse will offer ongoing support as required. Additionally, all vascular access and ancillary orders mentioned within may be refilled as directed for a duration of one year unless discontinued prior.

## VASCULAR ACCESS & ANCILLARY ORDERS

- Peripheral:
- Insertion of 22 or 24 gauge peripheral IV as required for ordered infusion therapy.
  - 0.9% sodium chloride 5 ml pre- and post-infusion.
  - 0.9% sodium chloride 10 mL pre- and post-infusion.
  - Other: \_\_\_\_\_

- Peripheral-Midline, PICC and Central Tunneled and Non-Tunneled:
- Access peripheral-midline, PICC, or central tunneled catheter as required.
  - 0.9% sodium chloride 5ml pre- and post-infusion. (5 mL pre-lab draw).
  - 0.9% sodium chloride 10mL pre- and post-infusion. (10 mL pre-lab draw).
  - Heparin (10 unit/mL) 5 mL post-use for flush/locking procedure
- For maintenance flushing/locking:**
- 10 mL of 0.9% sodium chloride followed by 5 ml Heparin (100 unit/mL)
  - Other: \_\_\_\_\_

- Implanted Port:
- Access the implanted port as required.
  - 0.9% sodium chloride 5ml pre- and post-infusion. (5 mL pre-lab draw).
  - 0.9% sodium chloride 10mL pre- and post-infusion. (10 mL pre-lab draw).
  - Heparin (10 unit/mL) 5 mL post-use for flush/locking procedure
- For maintenance flushing/locking:**
- 10 mL of 0.9% sodium chloride followed by 5 ml Heparin (100 unit/mL)
  - Other: \_\_\_\_\_

## CATHETER OCCLUSION ORDERS

**Cathflo Activase-** Instill into the occluded catheter. Let dwell for 30 minutes before attempting to aspirate. Dwell time not to exceed 120 minutes.

- 1 mg (midlines or patients <30 kg)     2 mg     **May repeat x 1 dose.**

## ANAPHYLAXIS ORDERS

### MILD REACTION – Pruritis or rash, dizziness without blood pressure change, arthralgia, headache, nausea

- Stop Infusion and connect 5-10 ml syringe and draw back to a blood return to remove the existing drug in the line and discard. Flush line with 10 ml of 0.9% sodium chloride.
- Diphenhydramine IV:**  
Dose:
  - 10 to 30 kg (22-66lbs) or (2-12 years old), 0.5ml (25mg) IV
  - >30 kg (>66lbs) or over the age of 12 years old, 0.5 ml (25mg) IV
  - >30 kg (>66lbs) or over the age of 12 years old, 1ml (50mg) IV
- May repeat x 1 Dose. (Maximum Adult Daily Dose 300mg/day)  
*Monitor vital signs at 15-minute intervals. If patient is back to baseline after 30 minutes, then restart the infusion. If patient is not back at baseline and symptoms persist, continue to monitor, and reassess for 15 additional minutes and to include vitals with each 15-minute interval. When patient is back to baseline restart infusion as tolerated. If mild symptoms persist, call primary ordering physician for guidance to continue or discontinue therapy.*

### SEVERE REACTION/ANAPHYLAXIS- Urticaria, hypotension, chest pain, shortness of breath, stridor, wheezing, vomiting, severe abdominal or back pain.

- Stop Infusion and connect 5-10 ml syringe and draw back to a blood return to remove existing drug in the line and discard. Flush line with 10ml of 0.9% sodium chloride. Call EMS 911.
- Epinephrine IM Injection:** (Do Not Delay Epinephrine in favor of other drugs/adjunctive therapies.)
  - Epinephrine IM Injection: **0.15ml/ 0.15mg, 5 to 30 kg (Children, 33 to 66 lbs.)** (Preferably thigh)
  - Epinephrine IM Injection: **0.3 ml/0.3mg, >30 kg (patients weighing > 66 pounds)**
  - If there is no response or an inadequate response, a second Epinephrine dose may be administered at 5 to 15 minutes after initial injection. Intramuscular injection is given into the mid-outer thigh.

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authorizing Prescriber Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ NPI: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Office Contact: \_\_\_\_\_