Palmetto INFUSION®

**Fax: 1-866-872-8920**

## IN HOME INFUSION

**Referral Date:**

☐ New referral ☐ Order change ☐ Order Renewal

# Intravenous Immune Globulin (IVIG) Unspecified Plan of Treatment

## 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 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:

| | | | |
|---|---|---|---|
| 1 | Insurance information | REQUIRED WASHOUT FROM PREVIOUS THERAPY: | |
| 2 | H&P including tried and failed therapies | | |
| 3 | Full medication list | | |

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

**IF ORDER CHANGE: Continue current order until insurance approved**

☐ Last Infusion Date:

Next Infusion Date:

## HOME SUPPLY ORDER:

All supplies for vascular access line care, dressing kit, drug administration, adverse reaction kit, Infusion pump, IV pole, pole clamp etc. will be provided.

## MEDICATION ORDERS:

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

**IV**

| | | | | | | |
|---|---|---|---|---|---|---|
| Diphenhydramine | ☐ | 25mg | ☐ | 50mg | ☐ | |
| Methylprednisolone | ☐ | 40mg | ☐ | 125mg | ☐ | |
| 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 500ml/hour)

**PO**

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

☑ **Home Anaphylaxis Kit:** Dispense 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 utlized 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:

**INDUCTION:_____gm/kg/day OR _____gm/day**

☐ One time dose ☐ Daily x____days

☐ Other: _____

**MAINTENANCE: _____gm/kg/day OR _____gm/day**

☐ Once ☐ Daily x____days

☐ Every _____weeks ☐ Other: _____

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

☐ 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 PIV/Access per PIV/PICC/CVC protocol.

**Dispense and Administer as Prescribed**

## 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 | |