

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> 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:

1	Insurance information
2	H&P including tried and failed therapies
3	Full medication list

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF ORDER CHANGE:

Continue current order until insurance approved

[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; UNLESS OTHERWISE NOTED BELOW

IV	Diphenhydramine	25mg	50mg		PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg	Other:		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			
	Other:					Other:				

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

INTRAVENOUS IMMUNE GLOBULIN DOSE:

_____ gm/kg/day
 _____ gm/day

FREQUENCY:

One time dose
 Daily x _____ days Once Every _____ weeks
 Once 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:

NURSING ORDERS:

- Start PIV/Access CVC
- Flush device per facility standard flushing procedure
- Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

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