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	

PO

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

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

☑ **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:_____

All doses to be administered in the home unless otherwise indicated

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	

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

1. 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.
2. **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
3. 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 to discontinue therapy.

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

1. 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.
2. **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:**	