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:

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		
	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/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:

NURSING ORDERS:

- [x] Start PIV/Access CVC
- [x] Flush device per facility standard flushing procedure
- [x] 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	