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:

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		
Methylprednisolone	☐	40mg	☐	125mg		
Famotidine	☐	20mg	☐	40mg		
Other:	☐					
Prehydration with NS	☐	250ml	☐	500ml	☐	1000ml
Posthydration with NS	☐	250ml	☐	500ml	☐	1000ml

Pre/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:	☐							

☑ **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 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:

☐ _____gm/kg/day
☐ _____gm/day

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

FREQUENCY:

☐ One time dose
☐ Daily x _____ days ☐ Once ☐ Every ___ weeks
☐ 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 > 101.5ºF 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 in the home setting unless otherwise indicated in special orders above

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 or 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:**	

Palmetto INFUSION

Checklist for referrals to Palmetto Infusion: Fax referral to 1.800.521.9640

- ☐ **Patient demographics - address, phone number, SS#, etc.**
- ☐ **Insurance information - copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com