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

Rev. 4.29.25

PATIENT DEMOGRAPHICS:

Patient Name:			
Patient's Phone:		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:

☑ 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.

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	