

Patient Information

Name			Parent/Guardian (if applicable)	
DOB	Height	Weight	Phone	Email
Address			City, State Zip	
<input type="radio"/> Male <input type="radio"/> Female First Dose of IVIG: <input type="radio"/> Yes <input type="radio"/> No			Prior Ig Brands Used	
Specific Adverse Reaction w/Prior Brands				
Allergies				

Diagnosis

- Combined Immunodeficiency, Unspecified **D81.9**
 Hereditary Hypogammaglobulinemia **D80.0**
 Other Combined Immunodeficiencies **D81.89**
 Common Variable Immunodeficiency, Unspecified **D83.9**
 Immunodeficiency w/Increased IgM **D80.5**
 Other: _____
 CVID w/Predominant Immunoregulatory T-Cell Disorders **D83.1**
 Nonfamilial Hypogammaglobulinemia **D80.1**

Prescription Information

Product: Pharmacist to Determine Physician Branded: _____

<input type="radio"/> Intravenous Immunoglobulin <input type="radio"/> 0.4 gm/kg <input type="radio"/> 1gm/kg <input type="radio"/> 2gm/kg <input type="radio"/> _____ grams Infuse: <input type="radio"/> IV daily over _____ days; repeat every _____ weeks; _____ cycle <input type="radio"/> Other: _____	<input type="radio"/> Subcutaneous Immunoglobulin Pharmacy to determine # of sites unless alt # of sites indicated here: _____ Infuse: <input type="radio"/> _____ grams subcutaneously; _____ times/week; for _____ months <input type="radio"/> Other: _____
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Infusion Rate: *Please select one and provide complete information*

Pharmacist to determine per manufacturer recommendations
 Start at _____ mL/hour then increase by _____ mL/hour every _____ minutes to maximum rate _____ mL/hour

IV Access: Peripheral PICC Port Other: _____

IV Maintenance (Flushing): *Dispense quantity sufficient*

Sodium chloride 0.9% 10mL prefilled syringe: flush IV access device with sodium chloride 1-10mL to maintain line patency
 Heparin 10 units/mL 5mL prefilled syringe: flush peripheral IV access device with heparin 10 units/mL 1-5 mL as needed to maintain line patency
 Heparin 100 units/mL 5mL prefilled syringe: flush implanted port with heparin 100 units/mL 3-5 mL as needed to maintain line patency

Pretreatment: *Dispense quantity sufficient*

Acetaminophen 325mg tablet: 1-2 tablets by mouth 15-30 minutes before each infusion Decline
 Diphenhydramine 25mg capsule: 1-2 capsules by mouth 15-30 minutes before each infusion Decline
 Other: _____

Ancillary Supplies: *Dispense ancillary supplies and equipment needed to provide home infusion therapy*

Labs: *Labs will not be drawn on weekends/holidays. Not for STAT labs.*

Labs to be drawn w/first course: _____ Frequency of labs: _____

Adverse/Anaphylactic Reactions: *Anaphylaxis kit to be used in the event of anaphylactic reaction and includes the below components*

Diphenhydramine 25mg capsule (qty 2), Diphenhydramine 50mg/mL 1mL vial (qty 1), Epinephrine injection auto-injector 0.3mg (>30kg pt) or 0.15mg (<30kg pt) (qty 1 two-pack), Sodium chloride 0.9% 500mL bag (qty 1), and Sodium chloride 0.9% 10mL prefilled syringe (qty 4)

Nursing Orders: *Nurse to administer IVIG and ancillary medications per orders. Skilled nursing visits for education of SCIG administration (not applicable if independent with therapy)*

Physician Information

Physician		Office Contact		
Address		City, State Zip		
Phone	Fax	License	DEA	NPI

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Prescriber's Signature	Date
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