AUTOIMMUNE PRESCRIPTION FORM

p 855-4-CARERX (855-422-7379) **f** 855-733-9898 **carefusionrx.com**

Care Fusion Rx

Patient Information

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

Diagnosis

- ○ Autoimmune Encephalopathy **G04.81**
- ○ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) **G61.81**
- ○ Dermatopolymyositis **M33.90**
- ○ Guillain-Barre Syndrome (GBS) **G61.0**
- ○ Inflammatory Neuropathies **G61.89**
- ○ Multifocal Motor Neuropathy **G61.82**
- ○ Myasthenia Gravis (MG) **G70.0**
- ○ Myasthenia Gravis w/Acute Exacerbation **G70.01**
- ○ Pemphigoid **L12.0**
- ○ Pemphigus **L10.9**
- ○ Polymyositis **M33.20**
- ○ Relapsing Remitting Multiple Sclerosis (RRMS) **G35**
- ○ Stiff Person Syndrome **G25.82**
- ○ Other: _____

Prescription Information

Product: ○ Pharmacist to Determine ○ Physician Branded: _____

○ Intravenous Immunoglobulin

○ 0.4 gm/kg ○ 1gm/kg ○ 2gm/kg ○ _____ grams

Infuse: ○ IV daily over _____ days;
repeat every _____ weeks; _____ cycle
○ Other: _____

○ Subcutaneous Immunoglobulin

Pharmacy to determine # of sites unless alt # of sites indicated here: ____

Infuse: ○ _____ grams subcutaneously;
_____ times/week; for _____ months
○ Other: _____

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

Prescriber's Signature	Date