promptcare

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C-2024

Intravenous Immune Globulin (IVIG) | Order Form

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City: _____ State: ____ Zip: _____

1. For new patients, please submit with form:

☒ Copy of insurance card ☒ Patient demographics ☒ Testing results supporting diagnosis
☒ History & physical ☒ Labs ☒ Baseline assessment (include medications tried and failed if any)

2. Patient Information

☐Male ☐Female Height: _____ in/cm Weight: _____ lbs/kg ☐ NKDA Allergies: _____
Has patient been on IG (IV or SQ) before? ☐ No ☐ Yes, list IG product and dose/frequency: _____
Date of last IG infusion (if known): _____ Is patient currently on **SCIG** and transitioning to IVIG? ☐ Yes ☐ No
List **SCIG** product, dose/frequency: _____ Desired start date for IVIG (if known): _____
Line: ☐ PIV ☐PICC ☐Port ☐Other

3. Diagnosis and Clinical Information

ICD-10 (required): _____
Primary diagnosis: ☐Congenital hypogammaglobulinemia ☐CVID ☐SCID ☐CIDP ☐Multifocal motor neuropathy ☐Multiple sclerosis .
☐Guillain-barré syndrome ☐Myasthenia gravis ☐Polymyositis ☐Dermatomyositis ☐ ITP ☐**Other:** _____

4. Prescription Information

IVIG Product	☒ **IVIG**: pharmacist to select product based on patient specific factors and notify provider of selection or change* ☐ Dispense as written, IVIG brand required: _____ Additional information: _____
Dose / Frequency	**Initial/loading dose:** _____ g/kg* (OR _____ grams) IV divided over _____ day(s) one time **Maintenance dose:** _____ g/kg* (OR _____ grams) IV divided over _____ days(s) every _____ weeks for _____ cycles **Other:** _____ ☐ *If weight is >130% ideal body weight (IBW), use adjusted body weight (IBW+0.4[ABW-IBW]) to calculate dose ☒ Round dose to whole vial size per policy
Administration	Infuse IV per manufacturer guidelines **OR** over _____ hours*. Titrate rate according to protocol, as tolerated.
Quantity / Refills	Dispense 1 month supply; Refill x 12 months ☐ Other: _____ Dispense all medical supplies necessary for infusion

5. Additional Orders

☒ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per PromptCare Policy and Procedure
Premedications: Give 30 min prior to infusions (*Note: if nothing is checked, no premedications will be given*)

Adults (or patients weighing >40kg):
☐ Diphenhydramine 25-50mg PO. Patient may decline.
☐ Acetaminophen 325-650mg PO. Patient may decline.
☐ Methylprednisolone 40mg (OR _____mg) slow IV push (or an equivalent corticosteroid, substitution if needed by pharmacy)

Pediatrics (weighing <40 kg): *(may adjust with weight changes)*
☐ Diphenhydramine 1mg/kg PO
☐ Acetaminophen 15mg/kg PO
☐ Methylprednisolone 1 mg/kg (OR _____mg) slow IV push (or an equivalent corticosteroid, substitution if needed by pharmacy)

☐ **Other:** _____

☒ RN to instruct patient to hydrate pre/post infusion and educate on taking OTC diphenhydramine and/or acetaminophen per manufacturer dosing recommendations as needed to prevent/treat post-infusion headache.
☒ RN to monitor patient for at least 30 min post infusion and educate on possible side effects, allergic reactions, and when to contact physician

6. Adverse Reaction Orders

Standard anaphylaxis kit to be dispensed and dosed per protocol: Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL vial), and NS IV.
Additional orders: _____

7. Prescriber Information

Prescriber Name: _____ Office Contact: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
License No.: _____ DEA NO.: _____ NPI:

_____

_____ _____ _____ _____
Physician Signature (Substitution Permitted) **Date** **Physician Signature (Dispense as Written)** **Date**