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C-2024

Intravenous Immune Globulin (IVIG) | Order Form

| atient Name: | | DOB: | Phone: Zip: | |
|--|---|--|---|--|
| | its, please submit with form: | | | |
| I of flew patien ⊠ Copy of insurance | | ⊠ Testing resu | ılts supporting diagnosis | |
| | . | - | sessment (include medications tried and failed if any) | |
| Patient Informa | | | , | |
| □Male □Female | Height: in/cm Weight: | lbs/kg NKDA / | Alleraies: | |
| Has patient been on | IG (IV or SQ) before? No Yes, list IG product | and dose/frequency: | | |
| Date of last IG infusi | ion (if known): Is patient currently on | SCIG and transitioning | ng to IVIG? ☐ Yes ☐ No | |
| | lose/frequency: | Desired start date fo | or IVIG (if known): | |
| Line: □ PIV □PICC | | | | |
| • | Clinical Information | | | |
| ICD-10 (required): _ Primary diagnosis: | □Congenital hypogammaglobulinemia □CVID | □SCID □CIDP | □Multifocal motor neuropathy □Multiple sclerosis | |
| | -barré syndrome □Myasthenia gravis □Polymyc | | yositis ITP Other: | |
| Prescription In | | | , some | |
| 1 rescription in | | | | |
| 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: | | | |
| | Initial/loading dose:g/kg* (ORgrain | ms) IV divided over _ | day(s) one time | |
| Dose / | Maintenance dose:g/kg* (OR grams) IV divided over days(s) every weeks for cycles | | | |
| Frequency | Other: □ *If weight is >130% ideal body weight (IBW), use adjusted body weight (IBW+0.4[ABW-IBW]) to calculate dose | | | |
| | ☐ 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 | | houre* Titrate re | ete according to protocol, as tolerated | |
| Administration | Infuse IV per manufacturer guidelines OR over hours*. Titrate rate according to protocol, as tolerated. Dispense 1 month supply; Refill x 12 months Other: | | | |
| Quantity / Refills | Dispense all medical supplies necessary for infusion | | | |
| Additional Ord | ers | | | |
| | pheral IV or use existing CVC. RN to administer cath | | | |
| Premedications: | Give 30 min prior to infusions (Note: if nothing is che | ecked, no premedicati ' | ions will be given) | |
| Adults (or patients weighing >40kg): | | Pediatrics (weighing <40 kg): (may adjust with weight changes) | | |
| | amine 25-50mg PO. Patient may decline. | ☐ Diphenhydramine 1mg/kg PO | | |
| | hen 325-650mg PO. Patient may decline. | ☐ Acetaminophen 15mg/kg PO | | |
| | nisolone 40mg (ORmg) slow IV push (or orticosteroid, substitution if needed by pharmacy) | ☐ Methylprednisolone 1 mg/kg (ORmg) slow IV push (or an equivalent corticosteroid, substitution if needed by pharmacy) | | |
| an equivalent c | orticosteroid, substitution if needed by priarmacy) | equivalent conticos | teroid, substitution in needed by pharmacy) | |
| ■ Other: | | · · · · · · · · · · · · · · · · · · · | | |
| ☑ DN to instruct pat | iant to hydrate pro/post infusion and aducate on taking | ng OTC diphophydrar | mine and/or acetaminophen per manufacturer dosing | |
| | s needed to prevent/treat post-infusion headache. | ig OTC diprientlydrai | Tille and/or acetaminophen per mandiacturer dosing | |
| | ient for at least 30 min post infusion and educate on | possible side effects, | allergic reactions, and when to contact physician | |
| | | | | |
| Adverse React | | | | |
| | | | vial), diphenhydramine IV/IM (50 mg/mL vial), and NS IV | |
| ditional orders: | | | | |
| Prescriber Info | rmation | | | |
| | | Office Contact: | | |
| Address: | | City: | t: | |
| Phone: | Fax: | | | |
| License No.: | DEA NO.: | | NPI: | |
| | | | | |
| | | | | |
| | | | | |
| Physician Signa | ture (Substitution Permitted) Date | Physician Si | ignature (Dispense as Written) Date | |

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