promptcare

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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 any tried/failed therapies)

2. Patient Information

☐Male ☐Female Height: _____ ☐in ☐cm Weight: _____ ☐lbs ☐kg ☐NKDA Allergies: _____
Has patient been on IG (IV or SQ) before? ☐Yes ☐No If yes, indicate product/relevant information: _____
Date of last IG infusion (if known): _____ Desired start date / next dose due: _____
Line: ☐PIV ☐PICC ☐Port ☐Other: _____ Any additional information: _____

3. Diagnosis and Clinical Information

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

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 and Frequency	☐**Loading** dose: _____ ☐grams OR ☐grams/kg, IV divided over ____ day(s) one time ☐**Maintenance**: _____ ☐grams OR ☐grams/kg, 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 Dose to be rounded to whole vial size per PromptCare Policy and Procedure unless otherwise indicated
Rate	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 OR ☐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 minutes post infusion and educateon possible side effects, allergic reaction, and when to contact provider

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), and NS IV. Additional orders: _____

7. Prescriber Information

Prescriber Name: _____ Office Contact: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
License #: _____ DEA #: _____ NPI: _____

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