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. IVIG Prescription 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**: _____ ● Dose to be rounded to whole vial size per PromptCare Policy and Procedure ● **If weight is >130% ideal body weight** (IBW), doses ordered in grams/kg will be calculated using adjusted body weight (IBW+0.4[ABW-IBW]) **unless** otherwise ordered: ☐Use actual body weight even if patient is >130% IBW
Rate	Infuse IV per manufacturer guidelines (OR over _____ hours). Titrate rate according to protocol, as tolerated
Product	Pharmacy to select clinically suitable Ig brand and notify provider of selection or change, unless Ig brand is specified by prescriber:_____
Quantity / Refills	Dispense 1 month supply (or quantity sufficient per order above) / Refill x 12 months unless otherwise noted 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**