

### Adult Intravenous Immune Globulin (IVIG) I Order Form

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

SSN#: \_\_\_\_\_ DOB: \_\_\_\_\_ Primary Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

#### 1 Patient Information

NKDA Allergies: \_\_\_\_\_

Wt: \_\_\_\_\_ lbs/kg Ht: \_\_\_\_\_ in/cm Male  Female

*\*Actual body weight will be used to dose IVIG. Adjusted Body Weight will be used when a patient has an Actual Body Weight greater than 130% IBW*

Is this the first dose: Yes  No  If no, list product: \_\_\_\_\_

Date of last infusion: \_\_\_\_\_ Next dose due: \_\_\_\_\_

Line type:  PIV  PICC  Port  Other: \_\_\_\_\_ Lumen #: \_\_\_\_\_

#### MUST SUBMIT WITH FORM

- Copy of insurance card
- Patient demographics
- Labs to include IgA level
- H&P
- For immune deficiency: Detailed infection history, baseline IgG levels (including subclasses), immune response to vaccinations (including Pneumorax report)
- Other: \_\_\_\_\_

#### 2 Diagnosis and Clinical Information

Primary ICD Code: \_\_\_\_\_ Secondary ICD Code: \_\_\_\_\_ Other ICD Code: \_\_\_\_\_

**SEE SECTION 7 ON THE THIRD PAGE FOR FULL LIST OF ICD-10 CODES**

#### 3 Prescription Information

Drug	Prescription/Dispensing	Quantity/Refills
<p><input checked="" type="checkbox"/> <b>Unbranded IVIG</b>  <i>(Pharmacist will determine best IVIG product based on patient specific factors. Ordering provider will be notified of initial product selection and any product changes)</i></p> <p><input type="checkbox"/> <b>Specific Brand Required:</b>            _____</p> <p><b>Reason for specific brand selection</b></p> <p><input type="checkbox"/> Patient Intolerance</p> <p><input type="checkbox"/> Other: _____            _____            _____</p>	<p><input type="checkbox"/> 0.4 gm/kg*</p> <p><input type="checkbox"/> 1 gm/kg*</p> <p><input type="checkbox"/> _____</p> <p>*Weight based does will be rounded to the nearest appropriate vial size</p> <hr/> <p style="text-align: center;"><b>Frequency</b></p> <p><input type="checkbox"/> Every _____ weeks (+/- 4 days)</p> <p><input type="checkbox"/> Daily x _____ doses</p> <p><input type="checkbox"/> _____</p> <hr/> <p style="text-align: center;"><b>Directions</b></p> <p>Infuse IV per manufacturer guidelines OR over _____ hours.</p> <p>Titration rate according to pharmacy protocol.</p>	<p>Dispense:</p> <p>1 month supply on all selected medications</p> <p>Refill x12 months unless otherwise noted.</p> <p><input type="checkbox"/> Other: _____            _____</p>

**4 Premedication Orders:**

RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per ARJ Policy and Procedure

Give premedication 30 minutes prior to infusion: (Note: If nothing is checked, no premeds will be given)

Diphenhydramine:  25-50 mg po OR  50 mg IV diluted in D5W or NS 50-100mL, infuse over 10-15min

Antihistamine:  Fexofenadine 180 mg po OR  Cetirizine 10 mg po

Methylprednisolone:  125 mg slow IV push over 5 mins. OR  \_\_\_\_\_ mg slow IV push over 5 mins.

Acetaminophen:  325-650 mg po OR  \_\_\_\_\_ mg po

D5W or NS 500mL - 1L IV over 30 minutes - 1 hour as tolerated daily PRN for hydration and/or headache

RN to instruct patient to hydrate pre/post infusion. RN to instruct patient to take Diphenhydramine 25-50 mg po and Acetaminophen 325-650 mg po every 4-6 hours for 24-48 hours as needed to prevent/treat post infusion headache.

Physician to be notified if headache persists or worsens

Other: \_\_\_\_\_  
\_\_\_\_\_

**5 Adverse Reaction Orders: (Dispense 1 dose of each medication below)**

In the event of an infusion reaction (ie: fever, chills, backache, headache) the following orders will be followed and the physician will be notified  
**Note: For mild Immune Globulin reactions, patient may be treated, and infusion resumed at a slower rate.**

STOP IVIG infusion. Infuse D5W or NS at 20 mL/hr to keep line open, may increase to 100-250 mL/hr for hydration. May give the following if stopping infusion does not resolve symptoms:

Diphenhydramine 50 mg IV diluted in D5W or NS 50-100 mL, infused over 10-15 minutes OR 50 mg/10 mL NS IV push over 2-3 minutes as tolerated.

Methylprednisolone 125 mg (OR \_\_\_\_\_ mg) slow IV push over 5 minutes.

Acetaminophen 325-650 mg (OR \_\_\_\_\_ mg) po at onset of symptoms.

Epinephrine (1:1000) by weight for use IM or SQ in anaphylactic reaction. May repaeat one time. EMS/911 will be called if used.

Other Instructions: \_\_\_\_\_

**6 Prescriber Information**

*By signing I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.  
ARJ Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.*

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

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**7 ICD-10 Codes**

**279.02 Selective IgM Immunodeficiency**

- D80.4 Selective Deficiency Immunoglobulin M (IgM)

**279.04 Congenital Hypogammaglobulinemia**

- D80.0 Hereditary Hypogammaglobulinemia

**279.05 Immunodeficiency with increased IgM**

- D80.5 Immunodeficiency with increased Immunoglobulin M (IgM)

**279.06 Common variable immunodeficiency (CVID)**

- D83.0 Common variable immunodeficiency w/ predominate abnormalities of B-cell numbers and functions
- D83.2 Common variable immunodeficiency with autoantibodies to B or T cells
- D83.8 Other common variable immunodeficiency
- D83.9 Common variable immunodeficiency, unspecified

**279.12 Wiskott-Aldrich syndrome**

- D82.0 Wiskott-Aldrich syndrome

**279.2 Severe Combined Immunodeficiency**

- D81.0 Severe combined immunodeficiency with reticular dysgenesis
- D81.1 Severe combined immunodeficiency with low T and B cell numbers
- D81.2 Severe combined immunodeficiency with low or normal B cell numbers
- D81.6 Major Histocompatibility complex class I deficiency
- D81.7 Major Histocompatibility complex class II deficiency
- D81.89 Other combined immunodeficiency
- D81.9 combined immunodeficiency, unspecified

**340 Multiple Sclerosis**

- G35 Multiple Sclerosis

**357.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)**

- G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

**358.00 Myasthenia Gravis without exacerbation**

- G70.00 Myasthenia gravis without (acute) exacerbation

**358.01 Myasthenia gravis with exacerbation**

- G70.01 Myasthenia Gravis with (acute) exacerbation

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_