

IMMUNE GLOBULIN (ADULT) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:



Patient Name:	Date of Birth:			
Address:				
Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:
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Immune Globulin Prescription

Immune globulin refill as directed x 1 year

Loading Dose: _____

Maintenance Dose: IV Subcutaneous

Infuse _____ gm for _____ day(s) every _____ week(s)

Infuse _____ gm/kg (BMI > 30, adjusted body weight used) divided over _____ day(s) every _____ week(s)

Other: _____

Pharmacist to identify clinically appropriate IG brand and infusion rates. May substitute product based on product availability.
Infuse entire contents of IG infusion bag/vial(s) per current dose. May infuse +/- 4 days to allow for patient scheduling.
Round dose to nearest whole 5 gm vial for IV doses and nearest single-use vial size for subcutaneous doses.

Ancillary Orders

Anaphylaxis Orders

IV Doses:

- Epinephrine 0.3 mg subcutaneously x 1 dose; may repeat x 1 dose in 5 to 15 min PRN.
- Diphenhydramine 25 mg IV or IM; may repeat x 1 dose in 15 min PRN if no improvement.
- Normal saline 500 mL IV at KVO rate PRN anaphylaxis or over 2 to 4 hours PRN headache rated > 5 on pain scale.

SQ Doses: Epinephrine Auto-Injector 0.3 mg 2-Pack Kit – Inject 0.3 mg IM x 1 dose PRN anaphylactic reaction, repeat x 1 PRN.

Pre-Medication Orders

Acetaminophen _____ mg PO 30 min before infusion. Patient may use own supply or patient may decline.

Diphenhydramine _____ mg PO 30 min before infusion. Patient may use own supply or patient may decline.

Other: _____

Other: _____

Other: _____

IV Flush Orders

Peripheral: NS 2 to 3 mL pre-/post-use. Heparin (10 unit/mL) 1 to 3 mL post-use.

Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Skilled nurse to administer doses intravenously where applicable. Skilled nurse to assess and teach self-administration of SQ medication where appropriate. Nurse will provide ongoing support, including administration of medication, PRN. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature:	Date:
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Prescriber Information

Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State:	Zip:	Office Contact:

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