IMMUNE GLOBULIN (ADULT) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
Address:		

Phone:	Height:	☐ inches ☐ cm	Weight:	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:

Immune Globulin Prescription

Immune globulin refill as directed x 1 year

Loading Dose: ☐ _____

Maintenance Dose: ☐ IV ☐ Subcutaneous

☐ Infuse _____ gm daily 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 SubQ or IM x 1 dose & repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg IV or IM; may repeat x 1 dose in 15 min PRN if no improvement.
- 0.9% Sodium Chloride 500 mL IV at KVO rate PRN anaphylaxis or over 30 minutes PRN headache rated > 5 on 0-10 pain scale

☒ SUBQ 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 and/or Laboratory 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: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use. Heparin (10 unit/mL) 1 to 3 mL post-use.

☐ Implanted Port: 0.9% Sodium Chloride 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 SUBQ medication where appropriate. Nurse will provide ongoing support, including administration of medication, PRN. Refill above ancillary orders as directed x 1 year.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

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

Prescriber Signature: **Date:**

Prescriber Information

Prescriber Name:	Phone:	Fax:
Address:	**NPI:**	

City, State:	Zip:	Office Contact:

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

