


# IMMUNE GLOBULIN (PEDIATRICS) PRESCRIBER ORDER FORM

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

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

## Clinical Information

<b>Primary Diagnosis Description:</b> _____	<b>ICD-10 Code:</b> _____
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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 the nearest single-use vial size.

## Ancillary Orders

### Anaphylaxis Orders

- IV Doses:**
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) subcutaneously x 1; repeat x 1 in 5 to 15 min PRN.
  - Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
  - Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.
- SQ Doses:** Epinephrine Auto-Injector 0.3 mg (≥ 30 kg) or 0.15 mg (15 to 30 kg) 2-Pack – Inject 1 dose IM x 1 PRN anaphylactic reaction, repeat x1 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: \_\_\_\_\_

### IV Flush Orders

- Peripheral:** NS 1 mL (2 to 20 kg) or 1 to 3 mL (> 20 kg) pre-/post-use and 1 to 3 mL (2 to 20 kg) or 3 to 5 mL (> 20 kg) pre-/post-lab draw. Heparin (10 unit/mL) 1 mL (2 to 20 kg) or 1 to 3 mL (> 20 kg) post-use.
- Implanted Port:** NS 1 to 3 mL pre-/post-use and 3 to 5 mL pre-/post-lab draw. Heparin (10 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (10 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.*

<b>Prescriber Signature:</b> _____	<b>Date:</b> _____
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## Prescriber Information

<b>Prescriber Name:</b> _____	<b>Phone:</b> _____	<b>Fax:</b> _____
<b>Address:</b> _____	<b>NPI:</b> _____	
<b>City, State:</b> _____	<b>Zip:</b> _____	<b>Office Contact:</b> _____

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