# IMMUNE GLOBULIN (PEDIATRICS) 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 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) SubQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg - 25mg max per dose) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

☒ SUBQ 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 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: _____

**IV Flush Orders**

☐ Peripheral: 0.9% Sodium Chloride 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: 0.9% Sodium Chloride 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 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:**



 