

| <b>IMMUNE GLOBULIN (PEDIATRICS) PRESCRIBER ORDER FORM</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                |                                                             |                                                                  |
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| Patient Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | Date of Birth: |                                                             | Gender:                                                          |
| 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:                                                |                                                                  |
| Immune Globulin Prescription                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                |                                                             |                                                                  |
| <b>Immune globulin refill as directed x 1 year</b><br>Loading Dose: <input type="checkbox"/> _____<br>Maintenance Dose: <input type="checkbox"/> IV <input type="checkbox"/> Subcutaneous<br><input type="checkbox"/> Infuse _____ gm daily for ____ day(s) every ____ week(s)<br><input type="checkbox"/> Infuse _____ gm/kg (BMI > 30, adjusted body weight used) divided over ____ day(s) every ____ week(s)<br><input type="checkbox"/> Other: _____<br><br>Pharmacist to identify clinically appropriate IG brand and infusion rates. May substitute product based on product availability.<br>Infuse entire contents of IG infusion bag/vial(s) per current dose. May infuse +/- 4 days to allow for patient scheduling.<br>Round dose to the nearest single-use vial size.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                |                                                             |                                                                  |
| Ancillary Orders                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                |                                                             |                                                                  |
| <b>Anaphylaxis Orders</b><br><input checked="" type="checkbox"/> 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.<br>▪ 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.<br>▪ 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.<br><input checked="" type="checkbox"/> 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                |                                                             |                                                                  |
| <b>Pre-Medication and/or Laboratory Orders</b><br><input type="checkbox"/> Acetaminophen _____ mg PO 30 min before infusion. Patient may use own supply or patient may decline.<br><input type="checkbox"/> Diphenhydramine _____ mg PO 30 min before infusion. Patient may use own supply or patient may decline.<br><input type="checkbox"/> Other: _____<br><input type="checkbox"/> Other: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                |                                                             |                                                                  |
| <b>IV Flush Orders</b><br><input type="checkbox"/> <u>Peripheral:</u> 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.<br><input type="checkbox"/> <u>Implanted Port:</u> 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.<br>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.<br>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>I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                |                                                             |                                                                  |
| Prescriber Signature:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                | Date:                                                       |                                                                  |
| Prescriber Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                |                                                             |                                                                  |
| Prescriber Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | Phone:         |                                                             | Fax:                                                             |
| Address:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | NPI:           |                                                             |                                                                  |
| City, State:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | Zip:           | Office Contact:                                             |                                                                  |
| <b>Fax completed form, insurance information, and clinical documentation to: 713-983-4647</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                |                                                             |                                                                  |
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