PREMIER INFUSION CARE

Immune Globulin (IG) Prescription Form

To: Premier Infusion Care	**Phone:** 866-365-2525	**Fax: 866-383-2525**	**Date:**
From:	**Phone:**	**Fax:**	**# Pages, Incl. Cover:**
Patient Name:	**Patient Phone:**		**DOB:**
Address:	**City:**	**State:**	**Zip:**

Primary Diagnosis:

ICD-10: Immunology

- ☐ C91.10 Chronic Lymphocytic Leukemia (CLL)
- ☐ D69.3 Idiopathic Thrombocytopenic Purpura
- ☐ D80.0 Bruton's X-linked Agammaglobulinemia
- ☐ D80.3 Selective IgG Immunodeficiency
- ☐ D80.4 Selective IgM Immunodeficiency
- ☐ D80.5 Hyper IgM
- ☐ D81.9 Severe Combined Immunodeficiency (SCID)
- ☐ D83.9 Common Variable Immunodeficiency (CVID)
- ☐ M30.3 Kawasaki Disease

ICD-10: Neurology

- ☐ G35 Multiple Sclerosis (MS)
- ☐ G60.9 Hereditary and idiopathic peripheral neuropathy–unspecified
- ☐ G61.0 Guillian-Barre syndrome (GBS)
- ☐ G61.81 Chronic inflammatory demyelinating polyneuropathy (CIDP)
- ☐ G61.9 Inflammatory and toxic neuropathy – unspecified
- ☐ G70.01 Myasthenia Gravis

ICD-10: Rheumatology

- ☐ M33.20 Polmyositis
- ☐ M33.90 Dermatomyositis

ICD-10: Transplant

- ☐ Z94.0 Kidney Transplant
- ☐ N17.9 Acute Renal Failure NOS
- ☐ N18.1 Chronic Kidney Disease Stage 1
- ☐ N18.2 Chronic Kidney Disease Stage 2
- ☐ N18.6 End Stage Renal Disease
- ☐ N19 Renal Failure Unspecified
- ☐ T86.10 Unspecified Complications of Transplanted Kidney
- ☐ T86.11 Kidney transplant rejection
- ☐ Z94.4 Liver Transplant
- ☐ T86.4 Unspecified Complications of Transplanted Liver
- ☐ T86.41 Liver transplant rejection
- ☐ Z94.1 Heart Transplant
- ☐ T86.20 Complications of Transplanted Heart
- ☐ T86.21 Heart transplant rejection
- ☐ Z94.2 Lung Transplant
- ☐ T86.30 Unspecified Complications of Transplanted Lung
- ☐ T86.810 Lung transplant rejection
- ☐ T86.0 Complications of Transplanted Bone Marrow
- ☐ T86.01 Bone marrow transplant rejection

In order to service your patient and facilitate insurance authorization, please complete applicable sections:

1

Ht: _____ ☐ in Wt: _____ ☐ lb Date: _____

- ☐ Patient demographics, including insurance information.
- ☐ Labs - Most recent BUN/SCr and IgA level
- ☐ H & P
- ☐ For immune deficiency: Detailed infection history, baseline IgG levels (including subclasses), immune response to vaccinations (including report)
- ☐ Other: _____

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Immune Globulin Prescription:

IVIG _____ **gm** *or* _____ **gm/kg** once **daily for** _____ day(s)

Repeat course every _____ week(s) x _____ course(s)

OR refill x _____ (length of time)

- *OK to round to the nearest vial size*
- +/- 4 days to allow scheduling flexibility ☐ Decline
- Multiple doses will be administered on consecutive days unless ordered otherwise.
  - ☐ consecutive *or* non-consecutive days
  - ☐ non-consecutive days only

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Please Complete/Select *One* of the SubQ Ig Orders Below:

Select Brand: ☐ **Hizentra 20%** ☐ **Gammagard Liquid 10%** ☐ **Gammaked 10%** ☐ **Gamunex - C 10%** ☐ **HyQvia**

☐ **Other:** _____

☐ IG: Hizentra conversion at **1:1.53 ratio**

Dose*: _____**gm**/_____**ml** **Frequency** _____

☐ IG: Gammagard Liquid, Gamunex - C, or Gammaked conversion at **1:1.37 ratio** (FDA approved conversion based on matching AUC of IV dose.)

Dose*: _____**gm**/_____**ml** **Frequency** _____

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Premier - Recommended Orders:

- Acetaminophen* dose (body weight): 650 mg (>45kg), 325 mg (26 - 45kg), 10 - 15 mg/kg (<26kg) po pre-IG. ☐ Decline
- Diphenhydramine* dose (body weight): 25 mg (>9kg), 1.25 mg/kg (<10kg) po pre-IG. May repeat dose in 30" as needed. ☐ Decline
- Lidocaine 2.5%/prilocaine 2.5% cream 30 gm: Apply to IV site during access prn. ☐ Decline
- Draw BUN/SCr annually while on service with Premier. ☐ Decline
- If recent lab results unavailable, draw BUN/SCr with first course.
- IG Anaphylaxis & ADR Prevention Kit orders (epinephrine, diphenhydramine oral/injectable, acetaminophen, NS bag) per Premier protocol are required. Please sign/return attached prescription.
- If applicable, flush intravenous access device per Premier protocol.
- Infusion pump(s) and supplies are necessary to administer therapy along with Nurse to administer first dose in the home care setting, start peripheral line (if needed) & administer IG/medications. ☐ Decline
- Refill ancillary medications x 1 year.
  *Liquid dosage form in appropriate concentration/amount may be dispensed based on patient age or request.

Access Device	Normal Saline Flush	Heparin
Peripheral	2 - 3 ml pre/post use	1 - 3 ml (10 units/ml) post use; maintenance q24hr
Peripheral-Midline	3 - 5 ml pre/post use; lab draw 5ml pre/10 ml post	3 ml (100 units/ml) post use; maintenance q24hr
PICC, Central Tunneled & Non- tunneled	5 ml pre/post use; lab draw 5ml pre/10 ml post	3 ml (heparin 100 units/ml) or 5 ml (10 units/ml) post use; maintenance q24hr
Implanted Ports	5 ml pre/post use; lab draw 5ml pre/10 ml post	3 - 5 ml (100 units/ml) post use; maintenance if accessed 3 - 5 ml q24hr or if not accessed 3-5 ml weekly to monthly
Valved Catheters Chest, PICC, Midline	5 - 10 ml pre/post use; 10 -20 ml pre/post lab draw; maintenance 5 -10 ml at least weekly	N/A

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

Prescriber Signature: _____ ☐ Dispense as written **Date:** _____

Physician Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Office Contact: _____

Hospital/Clinic Name: _____

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