IMMUNOGLOBULIN (IG) IV AND SUBQ ORDER FORM

P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Date of last infusion:** _____

MEDICAL INFORMATION

ICD-10 Code (required): _____ ICD-10 description: _____

Patient Weight: _____ lbs./kg. (required) Height: _____ If obese, use adjusted body weight? ☐ Yes ☐ No Diabetic ☐ Yes ☐ No

Allergies: _____ Brand previously used: _____

IMMUNOGLOBULIN THERAPY ORDER

☐ IV ☐ SubQ Active Infusions will identify clinically appropriate brand/infusion rates. May substitute based on patient's insurance and product availability.

Loading Dose (as applicable)	_____	☐ mg/kg ☐ gm/kg ☐ grams	x _____ day(s) **OR** divided over _____ day(s)	☐ One time dose ☐ Other: _____ **Give maintenance dose _____ days after loading dose**
Maintenance Dose	_____	☐ mg/kg ☐ gm/kg ☐ grams	x _____ day(s) **OR** divided over _____ day(s)	☐ Every _____ weeks x 1 year ☐ Other: _____

☐ Do not substitute. Administer brand: _____

- Infuse entire contents of Ig infusion bag/vial(s) per current dose.
- If needed, round dose to nearest whole 5gm vial for IV doses and nearest single-use vial size for SubQ doses.

Pre-Medication Orders: *to be administered 15-30 minutes before infusion*

☐ Acetaminophen 500mg PO
☐ Acetaminophen 1000mg PO
☐ Diphenhydramine 25mg PO / IV
☐ Diphenhydramine 50 mg PO / IV
☐ Solu-Medrol _____ mg IVP
☐ Loratadine 10mg PO
☐ Cetirizine 10mg PO
☐ Normal Saline 500mL IV
☐ Other: _____

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30 kg (>66lbs.): 0.3mg IM or subQ; may repeat in 5-10 minutes x 1
  - 15-30 kg (33-66lbs.) 0.15mg IM or subQ; may repeat in 5-10 minutes x 1
- Diphenhydramine 25-50mg PO or IV as needed
- Solu-Medrol 125mg IV as needed
- NS 250-500mL IV bolus as needed

Flush orders: NS 1-20mL pre/post infusion PRN

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____