IMMUNE GLOBULIN (ADULT) PRESCRIBER ORDER FORM							
Fax completed form, insurance information, and clinical documentation to:							
	Patient Name:	D		Date o	ate of Birth:		
option care health™	Address:						
option care nealth	Phone:		Height:	\Box inches \Box cm		Weight:	🗆 lbs 🗆 kg
Primary Diagnosis Do	escription:	al Information		ICD-10	0 Code:		
Immune Globulin Prescription							
Immune globulin refill as directed x 1 year							
Loading Dose:							
Maintenance Dose: IV ISubcutaneous							
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 nearest whole 5 gm vial for IV doses and nearest single-use vial size for subcutaneous doses. Ancillary Orders							
Anaphylaxis Orders							
☑ IV Doses: ■ Epinephrine 0.3 mg SubQ or IM x 1 dose & repeat x 1 in 5 to 15 min PRN. ■ Dickenhadrenning 25 mg W or IM and an and a set of 15 min PRN.							
 Diphenhydramine 25 mg IV or IM; may repeat x 1 dose in 15 min PRN if no improvement. 0.9% Sodium Chloride 500 mL IV at KVO rate PRN anaphylaxis or over 30 minutes PRN headache rated > 5 on 0-10 pain scale 							
SQ Doses: Epinephrine Auto-Injector 0.3 mg 2-Pack Kit – Inject 0.3 mg IM x 1 dose PRN anaphylactic reaction, repeat x 1 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:							
□ Other:							
IV Flush Orders							
Peripheral: NS 2 to 3 mL pre-/post-use. Heparin (10 unit/mL) 1 to 3 mL post-use.							
Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 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.							
Prescriber Signature: Date:							
Prescriber Name:			ber Information Phone:		Fax	x:	
					10		
Address: NPI:							
City, State: Zip:			Office Contact:				
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