IMMUNE GLOBULIN (ADULT) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

option care health™

Patient Name:			**Date of Birth:**	
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 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.
- 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 Information

Prescriber Name:		**Phone:**	**Fax:**
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

