

✂ Please detach before submitting to a pharmacy—tear here.

PATIENT INFORMATION

IG specialist: Name: _____ Phone: _____

Patient: see attached Gender: Male Female

Patient name: _____ DOB: _____ SSN: _____

Address: _____ City: _____

State: _____ ZIP: _____ Phone: _____ Cell: _____

Emergency contact: _____ Phone: _____ Relationship: _____

Insurance: Front and back of insurance card to follow

Primary Insurance: _____ Phone: _____ Policy #: _____ Group: _____

Secondary Insurance: _____ Phone: _____ Policy #: _____ Group: _____

Primary diagnosis:

Acute Infective Polyneuritis (Guillain–Barre Syndrome)	Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
Critical Illness Polyneuropathy (Acute Motor Neuropathy)	Multifocal Motor Neuropathy (MMN)
Myasthenia Gravis with (Acute) Exacerbation	Myasthenia Gravis without (Acute) Exacerbation
Peripheral Neuropathy (Unspecified)	Polymyositis
	Other: _____

Medical assessment: Height: _____ Weight: _____ lbs kg

Current medications? Yes No If yes, list or attach: _____

Allergies: _____

PRESCRIPTION ORDERS Medication infused per PI recommended rate and via rate controlled device per therapy

Immune Globulin: No preference Preferred product: _____

Directions: Infuse IV Infuse SC Per manufacturer guidelines or as written: _____ May round to the nearest 5gm vial size

Initial: gm/kg divided over _____ days; OR Other: _____

Ongoing: gm/kg divided over _____ days, every _____ weeks for _____ cycles; OR Other: _____

Quantity/Refills: 1-month supply; refill x 12 months unless otherwise noted Other: _____

Pre-medications 30 minutes before start of IG:

Acetaminophen PO	325 mg	650 mg	mg	DiphenhydrAMINE PO	25mg	50mg	mg
Hydration, solution:	Volume:	mL/hr:	Other:				

Nursing and other orders:

Administer IVIG or teach SCIG self-administration, via pump Ambulatory pump if required for infusion

Initiate access device (*insert peripheral IV, SC needles, access implanted port, or use existing PICC*)

Flush IV with 5mL 0.9% NaCl; Heparin 100 units/mL OR 10 unit/mL, 3-5mL PRN

Obtain labs (list): _____ Lab frequency: Once Monthly Other: _____

<input checked="" type="checkbox"/> Anaphylaxis kit order Infusion Reaction Management x1 year							
Mild	<ul style="list-style-type: none"> Slow infusion rate by 50% until symptoms resolve. Resume at previous rate as tolerated. <input checked="" type="checkbox"/> DiphenhydrAMINE PO 25mg 50mg mg Dispense diphenhydrAMINE 25mg capsules x 4 						
Moderate	<ul style="list-style-type: none"> Stop Infusion, resume at 50% rate when symptoms resolve <input checked="" type="checkbox"/> DiphenhydrAMINE IV 25mg 50mg mg Dispense diphenhydrAMINE 50mg vial x 1 						
Severe (Anaphylaxis) *Call 911* Notify prescribing physician	<ul style="list-style-type: none"> Stop infusion and remove tubing from access device to prevent further administration Initiate 0.9% NaCl 500mL/hr IV OR _____ mL/hr Dispense 0.9% NaCl 500mL x 1 Administer EPINEPHrine 1mg/mL by weight (Wt.) as an IM injection into the lateral thigh <table border="0"> <tr> <td>Wt > 66lbs (30kg)</td> <td>Wt 33 to 66 lbs (15 to 30kg)</td> <td>Wt < 33lbs (15kg)</td> </tr> <tr> <td>0.3mg/0.3mL</td> <td>0.15mg/0.15mL</td> <td>0.01mg/kg</td> </tr> </table> Repeat EPINEPHrine in 5 to 15 minutes if symptoms persist • Administer CPR if needed until EMS arrives Dispense EPINEPHrine x 2: 1mg vial Pen JR 0.15mg Pen 0.3mg Other: _____ 	Wt > 66lbs (30kg)	Wt 33 to 66 lbs (15 to 30kg)	Wt < 33lbs (15kg)	0.3mg/0.3mL	0.15mg/0.15mL	0.01mg/kg
Wt > 66lbs (30kg)	Wt 33 to 66 lbs (15 to 30kg)	Wt < 33lbs (15kg)					
0.3mg/0.3mL	0.15mg/0.15mL	0.01mg/kg					

PHYSICIAN INFORMATION

Name: _____ Practice: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ NPI: _____ Contact: _____

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

Substitution permissible Signature: _____ Date: _____ Dispense as written Signature: _____

This form is not a valid prescription in Arizona.