Immunoglobulin order form

Optum

Optum Infusion Pharmacy Phone: 1-877-342-9352 Fax: 1-888-594-4844

IG specialist: First Name: _____ Middle: _____ Last: _____ Phone: _____

Patient information

☐ see attached ☐ PEDIATRIC (younger than 13 years or less than 45kg in weight).

Patient First Name: _____ Middle: _____ Last: _____ Gender: ○ M ○ F DOB: _____

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

Phone: _____ ○ Home ○ Work ○ Cell Phone: _____ ○ Home ○ Work ○ Cell

Emergency contact: _____ Phone: _____ Relationship: _____

Insurance: ☐ Front and back of insurance cards attached.

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

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

Medical assessment

Primary diagnosis ICD-10 code (required): _____

Height in inches: _____ Weight **in kg only**: _____ Date weight (in kg) obtained: _____

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

Allergies: _____

☐ Patient requires a first lifetime dose and is to receive the first dose in the home or Optum Ambulatory Infusion Suite.

Prescription and orders

Medication to be infused per drug prescribing information recommended rate via a rate controlled device.

Immune Globulin: ☐ No preference ☐ Preferred product: _____ Dose will be rounded to the nearest vial or prefilled syringe size available.

Directions: ☐ Infuse IV ☐ Infuse SC ☐ Titrate per manufacturer guidelines or as written: _____

Initial loading: _____ gm/kg divided over _____ days every _____ weeks; OR _____ gm/day x _____ days every _____ weeks.

Maintenance: _____ gm/kg divided over _____ days every _____ weeks; OR _____ gm/day x _____ days every _____ weeks.

Other: _____

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

☑ Pharmacy to dispense flushes, needles, syringes and HME/DME in quantity sufficient to complete therapy as prescribed.

Premedication: Dispense PRN x 1 year (select below):

	Drug	Patient Type	Dose	Dispense detail	Directions
☐	DiphenhydrAMINE	Adult & Pediatric > 30 kg	50 mg (two 25 mg capsules or tablets)	Dispense 25 mg capsules or tablets #100	Administer orally 30 minutes prior to Ig therapy. May repeat once if symptoms occur.
		Pediatric 15 - 30 kg	25 mg (10 mL)	Dispense 2.5 mg / mL oral solution 120 mL	
		Pediatric < 15 kg	12.5 mg (5 mL)	Dispense 2.5 mg / mL oral solution 120 mL	
☐	Acetaminophen	Adult & Pediatric > 30 kg	325 mg	Dispense 325 mg tablets or 325 mg (10.15 mL) unit dose oral solution #100	Administer orally 30 minutes prior to Ig therapy. May repeat once if symptoms occur.
		Pediatric 15 - 30 kg	160 mg (5 mL)	Dispense 160 mg tablets #100 or 32 mg / mL oral solution 120 mL	
		Pediatric < 15 kg	80 mg (2.5 mL)	Dispense 32 mg / mL oral solution 120 mL	
☐	Hydration – Sodium Chloride 0.9% **specify volume and rate**	Adult & Pediatric	Volume _____ mL	Dispense bag(s) for infusion #QS	Infuse IV prior to IG, at a rate of: ☐ up to 250 mL / hr ☐ up to 500 mL / hr ☐ up to 900 mL / hr
☐	Lidocaine-Prilocaine Cream 2.5%	SCIG & Pediatric	n/a	Dispense 30 Gm	Prior to administration of IG apply pea size amount topically to needle site(s).
☐	Other, specify _____	_____	_____	_____	_____

Lab Draw Orders x1 year (specify): CMP ☐ monthly ☐ other _____ **Serum creatinine/BUN** ☐ monthly ☐ other _____

Other lab (specify): _____ Frequency ☐ once ☐ monthly ☐ other _____

Lab work to be obtained via IV access using aseptic technique. If RN is not able to draw labs from a central catheter, the labs may be drawn peripherally. RN to flush IV access after each blood draw with 20 mL of 0.9% Sodium Chloride. As final lock for patency, RN to use 5 mL of heparin 10 units / mL. If therapy is being administered through an implanted port, use 5 mL of heparin 100 units / mL.

Please fax both pages of this completed form with a copy of any medical history and labs relevant to the prescribed therapy.

This form is not a valid prescription in Arizona or New York.

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Nursing orders

RN to complete assessment and administer IVIG via ambulatory pump or teach SCIG self-administration via appropriate pump (e.g., syringe, ambulatory), in the home or Optum Ambulatory Infusion Suite. RN to insert / maintain / remove peripheral IV (PIVC) or access central venous catheter as needed using aseptic technique. RN to flush catheter with 5 mL of 0.9% Sodium Chloride pre infusion and post infusion. RN to rotate PIVC as needed for signs of infiltration or irritation.

If port, RN to access with non-coring port needle using sterile technique. De-access after infusion and apply pressure with sterile gauze. Apply transparent dressing to site. RN to use 10 mL sterile field 0.9% Sodium Chloride with needle change. Flush port with 10 mL of 0.9% Sodium Chloride pre infusion and post infusion. To maintain line patency following the post infusion flush, use 5 mL of heparin 100 units / mL. Discontinue port maintenance upon discontinuation of pharmacy services.

☑ **Anaphylaxis/infusion reaction management orders:** Dispense PRN x 1 year

Therapy Type	Drug	Patient Type	Dose	Dispense detail	Directions*
IVIG	DiphenhydrAMINE (for mild to severe symptoms)	Adult & Pediatric > 30 kg	50 mg (two 25 mg capsules or tablets)	Dispense 25 mg capsules or tablets #4	For mild* symptoms, RN to slow infusion rate by 50% until symptoms resolve. Administer diphenhydrAMINE orally once. May repeat once if symptoms persist. For moderate* to severe* symptoms, RN to stop infusion. Administer diphenhydrAMINE slow IV push at rate not to exceed 25 mg / minute. May repeat once if symptoms persist. For moderate* symptoms that resolve, resume infusion at 50% previous rate.
			50 mg (1 mL)	Dispense 50 mg / mL, 1 mL vial for injection #1	
		Pediatric 15 - 30 kg	25 mg (10 mL)	Dispense 2.5 mg / mL oral solution 120 mL (300 mg)	
			25 mg (0.5 mL)	Dispense 50 mg / mL, 1 mL vial for injection #1	
		Pediatric < 15 kg	12.5 mg (5 mL)	Dispense 2.5 mg / mL oral solution 120 mL (300 mg)	
			12.5 mg (0.25 mL)	Dispense 50 mg / mL, 1 mL vial for injection #1	
IVIG	EPINEPHrine (for severe symptoms)	Adult & Pediatric > 30 kg	0.3 mg (0.3 mL)	Dispense 1 mg vial for injection #2	For severe* symptoms (anaphylaxis), stop infusion. Disconnect tubing from access device to prevent further administration. Activate 911. Administer EPINEPHrine as an IM injection into the lateral thigh. Repeat EPINEPHrine in 5 to 15 minutes if symptoms persist. Initiate 0.9% Sodium Chloride IV. Administer CPR if needed until EMS arrives. Contact prescriber to communicate patient status.
		Pediatric 15 - 30 kg	0.15 mg (0.15 mL)	Dispense 1 mg vial for injection #2	
		Pediatric 7.5 kg - 15 kg	0.1 mg (0.1 mL)	Dispense Autoinjector Pen 0.1 mg (PED) #2	
SCIG	EPINEPHrine (for severe symptoms)	Adult & Pediatric > 30 kg	0.3 mg (0.3 mL)	Dispense Autoinjector Pen 0.3 mg #2	
		Pediatric 15 - 30 kg	0.15 mg (0.15 mL)	Dispense Autoinjector Pen JR 0.15 mg #2	
		Pediatric 7.5 - 15 kg	0.1 mg (0.1 mL)	Dispense Autoinjector Pen 0.1 mg (PED) #2	
IVIG	0.9% Sodium chloride (for severe symptoms)	Adult & Pediatric	500 mL	Dispense 500 mL bag #1	For severe symptoms administer as IV gravity bolus (1000 mL / hour).
IVIG	Other, specify _____	_____	_____	_____	_____

*Mild symptoms include flushing, dizziness, headache, apprehension, sweating, palpitations, nausea, pruritus, and / or throat itching.
Moderate symptoms include chest tightness, shortness of breath, > 20 mmHg change in systolic blood pressure from baseline, and / or increase in temperature (> 2°F).
Severe symptoms include > 40 mmHg change in systolic blood pressure from baseline, increase in temperature with rigors, shortness of breath with wheezing, and / or stridor.

Physician information

First Name: _____ Middle: _____ Last: _____ 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 Dispense as written signature Date

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