MORRISTOWN PHARMACY

IVIG PRESCRIPTION REFERRAL FORM

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Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Last updated: May 2017

Patient Name First Name Middle Name Last Name DOB Weight ☐ Male ☐ Female

Street Address Apt # City State Zip

Daytime Tel Evening Tel Cell Email

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed

DIAGNOSIS ☐ Polymiositis (M33.20) ☐ CVID (D84.9) ☐ CIDP (G61.81) ☐ Other specified diabetes mellitus with diabetic neuropathy, unspecified (E13.40)
☐ Guillian-Barre Syndrome (G61.0) ☐ Immune Neuropathy other than CIDP w/o Paraproteinemia (G61.81) ☐ Dermatomyositis (M36.0) ☐ Myathesnia Gravis (G70.0)
☐ Lambert-Eaton Syndrome, unspecified (G70.80) ☐ Polyneuropathy in diseases classified elsewhere (G63) ☐ Other

Insured's Name Relation to Patient Eligible for Medicare ☐ Yes ☐ No If yes, Medicare#

Prescription Card ☐ Yes ☐ No If Yes, Carrier Tel Fax Policy/Group#

Bin# Pcn# RXID# RX Group#

Prescriber's Name Office Contact

Street Address Suite # City State Zip

Tel Fax Email

License# NPI# UPIN# DEA#

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

Does patient already have a line? ☐ Yes ☐ No If yes, type of line
IVIG to be infused via existing line: ☐ Yes ☐ No
First IVIG Infusion?
☐ Yes If yes, IgA level is more than 5 mg/dl: ☐ Yes ☐ No ☐ Not Available
Ig Quantification: IgA, IgG, IgM (prior to 1st IVIG infusion)
☐ No If no, brand/dose of IVIG: Last infusion Date:
Note: IVIG contains IgA and is contraindicated in/gA deficient patients with antibodies against IgA and history of hypersensitivity.

IVIG (IMMUNOGLOBIN) ORDER: *(IVIG brand will be chosen if not specified)*

IVIG DOSE: g/kg = g (round to nearest vial size) infuse intravenously (Range: 0.2-2 g/kg)
☐ Repeat dose **daily** x consecutive days total, repeat dose: monthly x months
☐ Repeat dose **weekly** x weeks total
☐ Repeat dose **monthly** x months total
☐ Other

SUGGESTED RATE OF INFUSION:
☐ 30 -150 ml/hr as tolerated (Increase rate gradually every 30 min by 20-30 ml/hr)
☐ Other

PRE-MEDICATIONS: TO BE ADMINISTERED 30 MIN PRIOR TO IVIG INFUSION (QTY:PER INFUSION):
☐ Diphenhydramine 25 - 50 mg PO Dispense:#2 (25 mg)
☐ Acetaminophen 650 mg PO Dispense:#2 (325 mg)
☐ Other QTY: QS

IN THE EVENT OF ANAPHYLAXIS:
- Stop Infusion and call MD & 911
- Diphenhydramine 25 - 50 mg IVP every 4 hours prn (Not to exceed 25 mg/min) QTY: 3 (50 mg)
- Epinephrine (1:1000) 0.4 mg SQ prn anaphylaxis, may repeat every 20 minutes x 2 QTY: 3 amp

Other

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

SUPPLIES FOR INFUSION (If Necessary)
☐ NaCl 0.9% / D5W for flush: flush Line/Port with (3 - 5 ml for PIV and 5-10 ml for Central Line/Port) per nursing agency protocol *(NaCl 0.9% / D5W will be used based on IVIG compatibility)*
☐ Heparin for flush (100 Units / ml) (if RN keeps PIVor if needed for Central Line), flush with 3-5 ml per nursing agency protocol
☐ Sterile water for reconstitution of powder to make the requested concentration (for Carimune NF) ☐ Other:

Prescriber's Signature (signature required. NO STAMPS) **Date**