medix infusion

Immune Globulin Order Form
(IV Infusion)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: ________________________________ DOB: ____________ Phone: ____________________ Sex: M / F Ht: _____ Wt: _____ lbs / kg

Primary Language: ____________________ Allergies: ____

Patient Preferred Location: ___________________________________

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code (PROVIDE COMPLETE CODE)
- ☐ D80.______ Hypogammaglobulinemia or Select IG Deficiency
- ☐ D83.______ Common Variable Immune Deficiency
- ☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy
- ☐ M33.9______ Dermatopolymyositis
- ☐ M33.2.______ Polymyositis
- ☐ G61.0 Guillain-Barre Syndrome
- ☐ G70.00 Generalized Myasthenia Gravis, w/o Acute Exacerbation
- ☐ G70.01 Generalized Myasthenia Gravis, w/ Acute Exacerbation
- ☐ D69.3 Immune Thrombocytopenic Purpura

Other: __________________________

Prescribing Information

- IVIG product will be based on supply & availability, unless specified.
- Consider baseline assessment of blood viscosity in patients at risk for hyperviscosity, including those with cryoglobulins, fasting chylomicronemia/ markedly high triacylglycerois (triglycerides), or monoclonal gammopathies.
- Consider appropriate lab testing in patients with a higher risk of Hemolysis, including measurement of hemoglobin or hematocrit prior to infusion & within approximately 36 hours and again 7-10 days post infusion.

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
LAB RESULTS: **Renal function labs to include BUN/serum creatinine and BMP (if available). IgG Level required for immunodeficiency diagnosis.**

PRESCRIPTION

Pre-Medications
- ☐ Acetaminophen: 650 mg PO
- ☐ Diphenhydramine: 25 mg PO
- ☐ Diphenhydramine: 25 mg IVP
- ☐ Methylprednisolone: 125 mg SIVP

Other: ___________________________

Lab Orders

Immunodeficiency Diagnosis: IgG trough to be drawn every 12 weeks at infusion appointment.

Lab: ___________________________ Frequency: ________________

Lab: ___________________________ Frequency: ________________

Immune Globulin IV Infusion

Dose: **(SELECT ONE)** to avoid product waste: Adult Dosage is rounded to 5 gm vial, Pediatric Dosage is rounded to the nearest 1 gm vial.
Titrate per Medix Infusion protocol, as patient tolerates.
- ☐ **IV:** Infuse _____ gm/kg/day for one year
- ☐ **IV:** Infuse _____ gm per day for one year

Frequency: **(SELECT ONE)**
- ☐ Once
- ☐ Daily x ______ doses
- ☐ Every ______ weeks

Quantity to be Dispensed: ______ grams per month for one year
<<<<PRESCRIBER MUST COMPLETE QUANTITY TO BE DISPENSED & NUMBER OF REFILLS>>>>

Patient: Actual Body Weight+: __________ lbs **or** __________ kg

+dose based on actual body weight unless otherwise stated.

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

Home Infusion Patient Orders Only

IV Administer by Infusion Pump (Ambulatory Infusion Pump, Single or Multiple channels, Electric or Battery operated, with administrative equipment, worn by patient – E0781). Dispense infusion supplies for external drug infusion pump, per cassette or bag (A4222). Dispense supplies for maintenance of drug infusion catheter, per week (A4221). Per Medix Infusion protocol, an ANA kit which includes 50 mg of Diphenhydramine oral solution will be dispensed to home infusion patients.

Post Treatment Observations: The patient is observed for 30 minutes following the first infusion.

Comments: ____

PRESCRIBER INFORMATION

Prescriber Name: ______________________________________ ***Signature:*** ______________________________

Date: ____________________ NPI #: ____________________________ Specialty: ______________________________

Supervising Physician: ____ (If Applicable)

Address: ____ City: _________________________ State: __________ Zip: __________

Contact Name: ____________________ Phone: _____________ Fax: ________________ Email: ____________________________