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: ________________________________

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

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 Gullain-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
- IVG 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 triacylglyccerois (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. INCLUDE AUTH TO RELEASE PHI and/or POA (if applicable). *LAB RESULTS:* Please include brain MRI & CMP/BMP within 3 months.**

PRESCRIPTION*

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

Other: ______________________

IMMUNE GLOBULIN (IV Infusion)

Loading 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

Lab Orders
Immunodeficiency Diagnosis: IgG trough to be drawn every 12 weeks at infusion appointment.
Lab: ___________________ Frequency: ___________________
Lab: ___________________ Frequency: ___________________

Home Infusion Patient Orders Only
Administer by infusion Pump (Ambulatory Infusion Pump, Single or Multiple channels, Electric or Battery operated, with administrative eqipment, 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.

Is the patient on any other disease modifying therapy?
Yes No
If yes, please note therapy and last dose: ______________________

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.

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

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

Comments: ____

PRESCRIBER INFORMATION

Prescriber Name: ______________________________ Signature: ______________________________

Date: ______________ NPI #: __________________________ Specialty: ______________________________

Supervising Physician: ____ (If Applicable)

Address: ______________________________ City: ______________________________ State: __________ Zip:__________

Contact Name: ____________________ Phone: _______________ Fax: ______________ Email: ____________________