Clinical Specialty Infusions, LLC

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IMMUNE GLOBULIN AUTOIMMUNE DISORDER

PATIENT INFORMATION

Patient Name		Patient/Caregiver (if applicable)	
Address		City	State / Zip code
Main Phone	Alternate phone	Email Address	Social Security Number (required)
Date of Birth	Male or Female	Height (required) CM or INCH	Weight (required) KG
Is this the FIRST dose of Ig? No Yes		Prior Ig products used?	

Please include Facesheet, H&P, Clinicals and any available lab results.

CLINICAL INFORMATION - PRIMARY DIAGNOSIS - ICD-10

- ○ Acute Infective Polyneuritis (Guillain-Barre Syndrome) ICD-10___________
- ○ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) ICD-10___________
- ○ Dermatomyositis ICD-10___________
- ○ Inflammatory Polyneuropathy, Unspecified ICD-10___________
- ○ Multiple Sclerosis (MS) ICD-10___________
- ○ Multifocal Neuropathy (MMN) ICD-10___________
- ○ Myasthenia Gravis with (Acute) Exacerbation ICD-10 ___________
- ○ Myasthenia Gravis without (Acute) Exacerbation ICD-10___________
- ○ Pemphigus (Pemphigus Foliaceus, Pemphigus Vulgaris) ICD-10___________
- ○ Pemphigoid ICD-10___________
- ○ Polymyositis ICD-10___________
- ○ Stiff-Person Syndrome ICD-10___________
- ○ Other: ______________________________ ICD-10 ___________

PRESCRIPTION AND ORDERS

Administer: IVIG SQIG Specific IG Product if desired (Pharmacist will choose appropriate product for patient if left blank) ____________

Dosing (most common in neurological disorders):

- Loading dose: Immune globulin 10% **2 grams/kg** IV OVER **3-5** days • Refills ______________
- Maintenance: Immune globulin 10% **1 gram/kg** IV to be given every ________ weeks.

Custom dosing:

- Loading dose: Immune globulin 10% ________ grams/kg TOTAL IV infused OVER ________ days. • Refills ______________
- Maintenance: Immune globulin 10% ________ grams/kg IV TOTAL to be given every __________ weeks. Will infuse over 1-4 days based on patient tolerability.

Rate: start at 0.08ml/kg/min then titrate as tolerated up to a max rate of 0.8ml/kg/min OR to a lower individualized max rate based on patient tolerability.

Access: Peripheral PICC Port Other ______________________________

IV Maintenance (Flushing): Dispense quantity sufficient
- Sodium Chloride 0.9% 10ml syringe: Flush access device with 3-10ml as needed to maintain patency.
- Heparin 100 units/ml 5ml syringe: Flush peripheral IV access device with 3-5ml as needed to maintain patency.
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Pre-Treatment: Dispense Quantity Sufficient
- Acetaminophen 500mg tab: 1-2 tablets by mouth 15-30min prior to infusion
- Diphenhydramine 25mg tab: 1-2 tablets by mouth 15-30min prior to infusion
- Hydration - NS 0.9% 100-500ml IV over 30 before each infusion as needed

Adverse/Anaphylactic Reactions:
- Epinephrine 1:1000, 1ml ampule OR EpiPen 2pack
- Diphenhydramine 25mg tab #2
- Sodium Chloride 0.9% 1000ml Bag #1
- Diphenhydramine 50mg/1ml vial #1

PRN Orders:

Ondansetron 4mg slow IVP as premed for infusion induced nausea
Methylprednisolone 1mg/kg (12.5 - 125mg) slow IVP as premed or PRN for infusion related cutaneous reaction or headache
Other: ______________________________

Labs: Unless otherwise specified, the labs below will be drawn prior to each treatment when given IV. Labs for SubQ administration must be specified by prescriber.

Labs to be Drawn: CMP, CBC, CK ______________ Lab Frequency: ______________

Dispense ancillary supplies as needed to provide home infusion therapy including ambulatory pump and associated supplies.

Nursing Orders for Home Infusion MONITOR (IV Only)

Observe: Vital signs prior to infusion. Blood pressure and pulse every 15 minutes for first hour, then every 30 minutes until stable infusion rate, then every hour.

Watch for: Signs of fluid overload, cardiovascular symptoms, allergic reactions, skin rash, fever, and moderate to severe headache.

PHYSICIAN INFORMATION

Physician Name	Address	City	State	Zip Code
Phone	Fax	NPI	Practice Site Name	
Office Contact and special instructions:				

By signing this form and utilizing our services, you are authorizing CSI PHARMACY and it's employees to serve as your prior authorization agent when dealing with medical and prescription insurance companies.

______________________________ ______________________________
Prescriber's Signature (no stamps) Date

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