Clinical Specialty Infusions, LLC

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IMMUNE GLOBULIN ENROLLMENT FORM

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

o Acute Infective Polyneuritis (Guillain-Barre Syndrome)	ICD-10 - G61.0	o Myasthenia Gravis without (Acute) Exacerbation	ICD-10 - G70.00
o Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	ICD-10 - G61.81	o Pemphigus (Pemphigus Foliaceus, Pemphigus Vulgaris)	ICD-10 - L10.0
o Dermatomyositis	ICD-10 - M33.10	o Pemphigoid	ICD-10 - L12.0
o Inflammatory Polyneuropathy, Unspecified	ICD-10 - G61.89	o Polymyositis	ICD-10 - M33.20
o Multiple Sclerosis (MS)	ICD-10 - G35	o Stiff-Person Syndrome	ICD-10 - G25.82
o Multifocal Neuropathy (MMN)	ICD-10 - G61.82	o Other: _____	
o Myasthenia Gravis with (Acute) Exacerbation	ICD-10 - G70.01		

PRESCRIPTION AND ORDERS

Administer: ☐ IVIG ☐ SCIG Specific IG Product if desired (Pharmacist will choose appropriate product for patient if left blank) _____

IV Dosing (standard Neuro):

☐ Loading dose: Immune globulin 10% **2 grams/kg** IV OVER **5** days

☐ Maintenance: Immune globulin 10% **1 gram/kg** IV to be given every **4** weeks.

• Dispense 1 month supply; Refill 1 year

OR _____

Rate: start at 20ml/hr and titrate up based on the individual product to a max of 0.08 ml/kg/min. Rates will be individualized for each pt based on tolerability.

IV Dosing:

- INITIAL: _____ g/kg IV over _____ days
- ONGOING: _____ g/kg IV over _____ days every _____ weeks

Orders: _____

☐ • Clinical Pharmacist to dose and send orders for review/signature

Access: ☐ Peripheral ☐ PICC ☐ Port Other _____

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 per protocol:
- 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

☐ Toradol 15mg-30mg SIVP as premed for infusion induced headache or muscle pain

☐ Methylprednisolone 1mg/kg (12.5 - 125mg) slow IVP as premed or PRN for infusion related cutaneous reaction or headache

☐ Other: _____

Labs: CBC and CMP with each infusion OR _____

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 u tilizing our services, you are authorizing CSI PHARMACY and it's employees to serve as your prior authorization agent when communicating with medical and prescription insurance companies.

Prescriber's Signature (no stamps) _____ Date _____