

Pharmacy Name: _____ Phone: _____
 Address: _____ Fax: _____
 City/State/Zip: _____ Email: _____

Immune Deficiency Immunoglobulin Therapy

To	From	Number of Pages including Cover
Intake Phone	Phone	Fax
Patient Name	DOB	Date
Allergies	Height	Weight

Rx: Intravenous Route
 IVIG _____ grams daily for _____ day(s) OR IVIG _____ grams/kilogram daily given over _____ non-consecutive day(s)
 Repeat course every _____ week(s) for a total of _____ course(s) Dose will be rounded to nearest vial size.
 Peripheral Central
 Hydration: Infuse 500 mL of NS. Start at 100ml/hr 30 minutes before the IVIG starts; then run concurrently with IVIG infusion.

Rx: Subcutaneous Route
 IG _____ grams each month given as _____ doses OR IG _____ grams _____ times per month. Administer SCIG using _____ sites at a time. Repeat _____ week(s). Ok to round dose to nearest vial size. Refill x 1yr.

Diagnosis	ICD-10	Diagnosis	ICD-10
<input type="checkbox"/> Common Variable Immunodeficiency with Predominant Immunoregulatory T-Cell Disorders	D83.1	<input type="checkbox"/> Selective deficiency of Immunoglobulin M [IgM]	D80.4
<input type="checkbox"/> Wiskott-Aldrich Syndrome	D82.0	<input type="checkbox"/> Selective deficiency of Immunoglobulin G [IgG] Subclasses	D80.3
<input type="checkbox"/> Combined Immunodeficiency, Unspecified	D81.9	<input type="checkbox"/> Hereditary Hypogammaglobulinemia	D80.0
<input type="checkbox"/> Severe Combined Immunodeficiency [SCID] with Low T- and B- Cell Numbers	D81.1	<input type="checkbox"/> Immunodeficiency with Increased IgM	D80.5
<input type="checkbox"/> Severe combined Immunodeficiency [SCID] with Low or Normal B-Cell Numbers	D81.2	<input type="checkbox"/> Other Common Variable Immunodeficiencies	D83.8
<input type="checkbox"/> Selective deficiency of Immunoglobulin A [IgA]	D80.2	<input type="checkbox"/> Common Variable Immunodeficiency, Unspecified	D83.9

Other: _____
 IV Access Device Peripheral Central

Medi-Cal ID# _____ <input type="checkbox"/> Refill x 1 Year Per Home Care Services recommendation: <input type="checkbox"/> ACETAMINOPHEN 650 MG (325mg X 2) orally PRE-IVIG <input type="checkbox"/> DIPHENHYDRAMINE 25 MG orally PRE-IVIG <input type="checkbox"/> None <input type="checkbox"/> Other premed orders: _____ <input type="checkbox"/> Other premed orders: _____ <input type="checkbox"/> Other premed orders: _____ <input type="checkbox"/> Epi-Pen 0.3mg 2-Pak Auto-Injector	If applicable, flush intravenous access device per Home Care Services protocol: <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th style="width: 30%;">Access</th> <th style="width: 35%;">NS</th> <th style="width: 35%;">Heparin 100 u/mL</th> </tr> </thead> <tbody> <tr> <td>Peripheral</td> <td>1 - 3 mL before/after use</td> <td>1 - 3 ml after last NS</td> </tr> <tr> <td>Midline, Central (Non-Port), PICC</td> <td>3 - 5 mL before/after use 5 - 10 ml after blood draw</td> <td>3 - 5 ml after last NS</td> </tr> <tr> <td>Implanted Port</td> <td>5 - 10 mL before/after use 10 - 20 ml after blood draw</td> <td>5 ml after last NS</td> </tr> <tr> <td>Groshong PICC, Midline</td> <td>5 - 10 mL before/after use 10 - 20 mL after blood draw</td> <td>None</td> </tr> </tbody> </table>	Access	NS	Heparin 100 u/mL	Peripheral	1 - 3 mL before/after use	1 - 3 ml after last NS	Midline, Central (Non-Port), PICC	3 - 5 mL before/after use 5 - 10 ml after blood draw	3 - 5 ml after last NS	Implanted Port	5 - 10 mL before/after use 10 - 20 ml after blood draw	5 ml after last NS	Groshong PICC, Midline	5 - 10 mL before/after use 10 - 20 mL after blood draw	None
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If needed, a Basic Metabolic Panel (Chem 7) to be drawn prior to first dose. If necessary Patient may have first dose administered in the home by a skilled nurse, unless instructed otherwise. Pharmacy to provide all equipment and medical supplies necessary to administer therapy as appropriate.

Prescriber Signature: _____
 Print Prescriber Name _____ NPI# _____

Please fax the following information:
 Immunoglobulin order - include dose, route of administration, frequency, duration, and any pre-medications OR use prescription order section above
 Patient demographics - include insurance information. We will obtain authorization unless the insurance dictates otherwise
 H & P OR progress note(s) describing diagnosis and clinical status
 Labs - BUN/Creatinine (preferred within last 90 days), Immunoglobulin Panel

I authorize Fannin Infusion Pharmacy and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Fannin Infusion Pharmacy. Physician Signature: _____
 Date: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

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