

PATIENT INFORMATION

Patient Name		Parent/Guardian Name (if applicable)	
Date of Birth	☐ Male ☐ Female	Weight (Required) ☐ kg ☐ lbs	Height (Required) ☐ ft ☐ in
Address		City, State, Zip Code	
Main Phone	Alternate Phone	Email	
Other Drugs Used to Treat Patient's Condition		First Dose of IVIG: ☐ Yes ☐ No If no, when was last: _____	Prior Ig Products Tried
Adverse Reactions with Previous Treatments		Allergies	

CLINICAL INFORMATION - PRIMARY DIAGNOSIS

☐ 294.0 Kidney Transplant ☐ 294.1 Heart Transplant ☐ 294.2 Lung Transplant
☐ Other: _____ ICD-10: _____

Please include the following information:
☐ Demographics ☐ H&P ☐ Physician Orders ☐ Insurance Information

PRESCRIPTION AND ORDERS

Administer: ☐ SCIG ☐ IVIG **Access:** ☐ Peripheral ☐ PICC ☐ Port ☐ Other: _____
Product: ☐ Pharmacist to determine OR ☐ Formulation: _____

Dose (please select option(s) and provide complete information, pharmacy to round the nearest 5 gram vial):
☐ Loading Dose: _____ gm/kg OVER _____ day(s), then
☐ Maintenance Dose: _____ gm/kg OVER _____ day(s), EVERY _____ week(s) x _____ cycles
☐ Other Regimen: _____

Infusion Rate: (Please select one and provide complete information)
☐ Pharmacist to determine
☐ Start at _____ mL/hr, then increase by _____ mL/hr every _____ minutes to maximum rate _____ mL/hr

IV Maintenance (Flushing): Dispense Quantity Sufficient

- Sodium chloride 0.9% 10 mL Prefilled Syringe: Flush IV access device with sodium chloride 3-10 mL to maintain line potency
- Heparin 10 units/mL 5 mL Prefilled Syringe: Flush peripheral IV access device with Heparin 10 units/mL 1-5 mL as needed to maintain line potency
- Heparin 100 units/mL 5 mL Prefilled Syringe: Flush central IV access device with Heparin 100 units/mL 3-5 mL as needed to maintain line potency

Adverse/Anaphylactic Reactions: Anaphylaxis kit to be used in the event of anaphylactic reaction and will contain the following:

- Diphenhydramine 25mg capsule #2
- Diphenhydramine 50mg/mL 1mL vial #1
- Sodium chloride 0.9% 500 mL Bag #1
- Epinephrine injection Auto Injector 0.3mg (>30 kg pt) / 0.15 mg (<30 kg pt) two pack #1
- Sodium chloride 0.9% 10 mL Prefilled Syringe #4

Pre-Treatment: Dispense Quantity Sufficient

- Acetaminophen 325mg Tablet: 1-2 tablets by mouth 15-30 minutes before each infusion
- Diphenhydramine 25mg Capsule: 1-2 capsules by mouth 15-30 minutes before each infusion
- Other: _____

Ancillary Supplies: Dispense ancillary supplies and equipment needed to provide home infusion therapy.

Labs: Results will be faxed to physician's office. If no frequency noted, ordered labs to be done prior to initial infusion only. Labs will not be drawn on weekends/holidays. Not appropriate for STAT labs.
Please provide patient's latest lab results: ☐ CBC & CMP

Nurse Orders: Skilled Home Infusion Nursing to Administer IVIG as outlined in MD order

- 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.
- Call/Page MD:** For adverse events, stop the infusion. Can restart the infusion at the same or lower rate pending physician's approval or if symptoms subside.
- Skilled RN: To teach/train administer SQ via pump with necessary supplies for each subcutaneous infusion up to 3 visits. RN to notify pharmacy directly if patient is unable to self administer.**

PHYSICIAN INFORMATION

Physician Name	DEA #	NPI #	License #
Address		City, State, Zip Code	
Phone	Fax	Office Contact	

By signing this form, you are authorizing Mercy LTC & Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payors with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Prescriber's Signature (no stamps)

Substitution Permitted

Date

Prescriber's Signature

Dispense as Written

Date