Mercy LTC & Specialty Pharmacy
A Member of Mercy Pharmacy Group

FAX: 562.402.4629

Immune Globulin Autoimmune Disorder

Version: 5/6/2025

PATIENT INFORMATION

Patient Name		Parent/Guardian Name (*if applicable*)	
Date of Birth	○ Male ○ Female	Weight (Required) ○ kg ○ lbs	Height (Required)
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

○ Acute Infective Polyneuritis (Guillain-Barre Syndrome)	G61.0	○ Myasthenia Gravis with (Acute) Exacerbation	G70.01
○ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	G61.81	○ Myasthenia Gravis without (Acute) Exacerbation	G70.00
○ Dermatopolymysotis, Unspecified, Organ Involvement Unspecified	M33.90	○ Pemphigus (Vulgaris, Foliaceus, Unspecified)	○ L10.0 ○ L10.2 ○ L10.0
○ Multifocal Motor Neuropathy (MMN)	G61.82	○ Polymyositis	M33.20
○ Inflammatory Polyneuropathy, Unspecified	G61.9	○ Stiff-Person Syndrome	G25.82
○ Multiple Sclerosis (MS)	G35	○ Other: _____	

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 — Refill x 1 year ○ Decline
- Diphenhydramine 25mg Capsule: 1-2 capsules by mouth 15-30 minutes before each infusion — Refill x 1 year ○ Decline

○ 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	

Prescriber's Signature (no stamps)	Substitution Permitted	Date	Prescriber's Signature	Dispense as Written	Date