



Immune Deficiency Immunoglobulin Therapy Patient Referral and Prescription Sheet

Return Signed RX via Fax to 561.353.4666

To: Karen Kaczmarek, Pharm.D	From:	Phone:
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Intake phone: 561.353.4663	Fax:	Number of Pages (Including Cover):
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Date:	DOB:	Allergies:
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Patient Name:	Height:	Weight:
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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.

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

Diagnosis:	ICD-9	ICD-10	Diagnosis:	ICD-9	ICD-10
<input type="checkbox"/> Common Variable Immunodeficiency with Predominant Immunoregulatory T-Cell Disorders	279.10	D83.1	<input type="checkbox"/> Selective deficiency of Immunoglobulin M [IgM]	279.02	D80.4
<input type="checkbox"/> Wiskott-Aldrich Syndrome	279.12	D82.0	<input type="checkbox"/> Selective deficiency of Immunoglobulin G [IgG] Subclasses	279.03	D80.3
<input type="checkbox"/> Combined Immunodeficiency, Unspecified	279.2	D81.9	<input type="checkbox"/> Hereditary Hypogammaglobulinemia	279.04	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	279.05	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	279.06	D83.8
<input type="checkbox"/> Selective deficiency of Immunoglobulin A IgA]	279.01	D80.2	<input type="checkbox"/> Common Variable Immunodeficiency, Unspecified		D83.9
			<input type="checkbox"/> Other:		

IV Access Device: Peripheral Central
 Hydration: Infuse 500 ml of NS. Start at 100ml/hr 30 minutes before the IVIG starts; then run concurrently with IVIG infusion.

Premedication Orders: Refill x 1Year

Per Home Care Services recommendation:
-ACETAMINOPHEN 650 MG (325mg X 2) orally PRE-IVIG
-DIPHENHYDRAMINE 25 MG orally PRE-IVIG

None
 Other premed orders: _____
 Other premed orders: _____
 Other premed orders: _____
 Epi-Pen 0.3mg 2-Pak Auto-Injector

If applicable, flush intravenous access device per Home Care Services protocol:

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

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: _____ **Date** _____
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

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