MedRX Infusion
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Date Medication Needed: _____

Delivery location: _____

Immunoglobulin Infusion Therapy

This referral form is provided in order to best serve our patients and prescribers. Patients may choose any pharmacy of their choice.

Complete patient demographics below or otherwise provide the information requested along with this referral form. Also needed: 1) Patient insurance information (front and back of card) 2) History and physical, chart notes, laboratory results and other diagnostic tests needed to support the use of this medication 3) patient's medication history related to their current diagnosis/problem.

Patient name: _____ Date of birth: _____ height: _____ weight: _____

Address: _____ Allergies/Intolerances: _____

Phone number(s): _____ ☐ No known allergies: _____

Treatment Diagnosis/Problem(s): _____

Therapy is going to be administered ☐ physicians office ☐ infusion suite ☐ in patients home

☐ Patient has an existing intravenous access device (catheter type) _____ date placed _____

Prescriber name: _____ Contact person: _____

Office Address: _____

Phone number: _____ Fax number: _____ NPI number: _____

IVIG (Intravenous Immunoglobulin(specify product and final % if desired, otherwise the Pharmacist will decide upon the brand/strength based upon the patient's clinical condition) Dose:_____ grams intravenously once every __ _____ days for _____days/months. This represents _____ mg/kg/day.

☐ To be infused intravenously based upon the product package insert recommendations for the product based upon the patient's weight with the dose tapering up every 30 minutes as tolerated (as assessed by the infusion nurse), with a maximum rate of 200 ml/hr or _____ ml/hr.

Or ☐ my specific infusion rate directions: _____

The patient should receive the following medications 30 minutes prior to the start of the IVIG infusion:

☐ Ibuprofen 400 mg acetaminophen 650 mg po ☐ diphenhydramine 25 mg po ☐ other _____

☐ The patient may take an additional dose of _____ every 4 hours if needed for headache, malaise, body aches

Anaphylaxis kit (with epinephrine and diphenhydramine, with supplies to administer) on hand for all infusions (see separate anaphylaxis kit approval order)

☐ Home Health care nursing is needed. The Home Health nurse will establish the intravenous catheter (peripheral if needed) or otherwise access and maintain the venous catheter, per protocol and stay with the patient during the entire infusion and 30 minutes after completion of the infusion, or as directed by the physician. The RN/LVN will take and record the patient's baseline vital signs. During the infusion, blood pressure, temperature and respiratory rate are to be monitored and recorded every 15 minutes or as specified by the physician. If there are significant changes out of the normal range or from baseline during the infusion, stop the infusion and notify the physician or pharmacist.

The Pharmacy will supply catheter flushing products which may include heparin 100 units/ml, sodium chloride 0.9%, supplies and infusion pump to administer the IVIG..

Physicians Signature:_____ Date: _____

IMPORTANT NOTICE: This form my contain confidential and privileged information and is only intended only for the person named herein. If you are not the named addressee, do not disseminate, distribute or copy this form or any of its contents. Please notify the sender immediately if you have received this document by mistake, then destroy this form.