Specialty Injections Order Form
IV Immunoglobulin Therapy

Date: ______________

61 Doctor's Park • Cape Girardeau, MO 63703
866-936-1999 • Fax (573) 335-7233

Prescriber's Name: ______________ MD / DO / NP / PA

Address: ______________

City ______________ State ______________ Zip ______________

Office Contact: ______________ Phone# ______________ Fax# ______________

NPI: ______________ DEA: ______________ License: ______________

PATIENT INFORMATION Send updates to ❑ Fax ❑ E-mail to ______________ ❑ Text to Phone# ______________

Patient's Name: ______________ SS# ______________ DOB: ______________

Address: ______________ City ______________ State ______________ Zip ______________

Home Phone: ______________ Work or Cell: ______________ Emergency Contact: ______________

Allergies: ______________ Sex: M___ F___ Wt: ______________ Ht: ______________ Diabetic: Y N

Patient previously on treatment: Y N Date: ______________

Primary Insurance: ______________ Policy# ______________

Insured: ______________ Group ______________

Phone: ______________ BIN# ______________ PCN# ______________

*** Please include current patient medication list with referral ***

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS: (ICD-9 CM Code Plus Description) Date of Diagnosis: ______________

PID 270.00, ITP 287.31, CLL 204.1, Kawasaki Syndrome 446.1, NOS 279.3, **For off label use call office.**
For Vivaglobin Sq IgG please call Special Design Health Care for Enrollment form.

SHIP MEDS

❑ Home ❑ Doctors Office

Anticipated Start Date ______________

Infusion by: ❑ Special Design Healthcare ❑ Drs. Office
❑ Home Health Agency ______________

IVIG 300-600 mg/kg/dose

Gammagaurd 10% ______________ GMs, IV over ______________ hours every 21 / 28 Days **(circle one)**

Gammagaurd will be used unless specified:
❑ Gamunex 10%, ❑ Carimune, ❑ Flebogamma 5%, ❑ Octagam 5%

IVIG will be tapered up over 40-60 minutes via a CADD pump program.

IVIG to run no faster than 10 gm/ hr unless specified by physician

Saline PFS 10ml Flush before and after infusion #qs Refill prn

Heparin 100u/ml 3-5ml Flush after infusion #qs Refill prn

Refill X______ Months

❑ Nurse to obtain IV access for dose and then D/C access at end of dose.

❑ Nurse to access Port-A-Cath for dose and then D/C huber needle after dose complete.

❑ SDHC nurse; Skilled nursing visit for high tech infusion.

VS: Pre-infusion then, every 15 minutes x3 then, every hour until complete.

CBC, BUN, Creatinine, ALT, AST, IgG level With every 3rd dose and faxed to physician with Pt height and weight for dose adjustment if required.

Premedications

❑ Diphenhydramine (Benadryl®) 25mg Orally 30 minutes before infusion
❑ Acetaminophen (Tylenol®) 650 mg Orally 30 min before infusion
❑ Methylprednisolone (Solu-Medrol®) 60 mg IV
❑ Prednisone 40 mg ORALLY

Adverse Reactions

❑ Acetaminophen (Tylenol®) 650 mg ORALLY for fever or mild discomfort.
❑ Diphenhydramine (Benadryl®) 50 mg ORALLY for mild to moderate allergic reactions
❑ **EpiPen or Epinepherine 0.3mg SQ for anaphylactic reactions and contact physician.**
Authorized x1 year

By signing this form and utilizing our services, you are authorizing SDHC and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature: ______________ May Substitute ______________ Dispense as Written Date: ______________