

IVIG PRESCRIPTION FORM

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

altScripts Specialty Pharmacy
 1636 Miller Park Way, West Milwaukee, WI 53214
 Phone: 414-385-9500 Fax: 414-385-7200
 www.altscripts.com



Patient Information: please provide a copy of the patient's insurance card or information						
Patient name:		DOB:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M	HT:	WT:	
Address:		City:	State:	Zip Code:	Phone:	
Insurance:	Subscriber's name:		ID#:	Group #:		
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> List allergies:						
Clinical Information: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization						
Diagnosis / ICD-10:		IVIG indication required for administration: <input type="checkbox"/> Idiopathic Thrombocytopenic Purpura <input type="checkbox"/> Primary Immunodeficiency Syndrome <input type="checkbox"/> Chronic Inflammatory Demyelinating Polyneuropathy <input type="checkbox"/> Other (specify):				
Vital Signs: <input type="checkbox"/> Monitor BP q15min for the first hr of initial infusion, then q30-60min for the remainder of IVIG infusion <input type="checkbox"/> Monitor BP q30-60min for subsequent IVIG infusions						
Notify Physician if any of the following are observed: <input type="checkbox"/> SBP is less than 90 mmHg or greater than 180 mmHg <input type="checkbox"/> DBP is less than 50 mmHg or greater than 90 mmHg <input type="checkbox"/> Temperature is greater than 101.5 degrees F <input type="checkbox"/> Heart Rate is less than 50 or greater than 120 <input type="checkbox"/> RR is less than 10 or greater than 30 respirations/min <input type="checkbox"/> Urine Output is less than 30 mL/hr or 240 mL/shift <input type="checkbox"/> Pulse Oximetry is less than 90% <input type="checkbox"/> SBP is less than 90 mmHg or greater than 180 mmHg						
Blood Test: CBC, Metabolic Panel (chem-7) daily, prior to each infusion, Immunofixation, Immunoglobulins quantitation (Before 1st/ _____ treatment, fax results to pharmacy)						
Treatment						
Decrease IVIG rate or stop infusion and notify physician if patient experiences adverse reactions: hypotension, chest tightness, fever, chills, or nausea/vomiting		Pre-Medication: <input type="checkbox"/> Acetaminophen 650 mg po one time 30-60 min prior to each dose of IVIG <input type="checkbox"/> Diphenhydramine 25 mg po one time prn 30-60 min prior to each dose of IVIG <input type="checkbox"/> Other:				
Immune Globulin: <input type="checkbox"/> Predisposed to renal insufficiency, minimize rate of infusion <input type="checkbox"/> Patient has not been treated previously with IVIG, initiate at a lower concentration or lower rate		Pharmacist will round down to nearest vial and maintain at least 90% of calculated dose. If dose deviates by more than 10% of calculated dose, Pharmacist may round up to nearest vial. <input type="checkbox"/> Patient has been previously treated with IVIG and tolerated therapy <input type="checkbox"/> Patient has NOT been previously treated with IVIG <input type="checkbox"/> Pharmacist to use current weight for dose calculations <input type="checkbox"/> Use (specify): _____ kg as dosing weight <input type="checkbox"/> Immune globulin 0.4 g/kg IV daily initiate first dose at 15 to 30 mL/hr and increase rate every 30-60 minutes for duration of the infusion. For subsequent doses, titrate every 15 to 30 minutes to a final maximum rate listed in infusion table.				
Intravenous Immune Globulin Infusion Table						
Product & Concentration		Titrate as Tolerated to the Following Maximum Rates based on Patient Weight				
		60 kg	70 kg	80 kg	90 kg	100 kg
Standard IVIG 6%		120 mL/hr	140 mL/hr	160 mL/hr	180 mL/hr	200 mL/hr
Standard IVIG 12%		60 mL/hr	70 mL/hr	80 mL/hr	90 mL/hr	100 mL/hr
Sucrose Free IVIG 10% (Privigen®)		140 mL/hr	165 mL/hr	190 mL/hr	215 mL/hr	240 mL/hr
Sucrose-Free IVIG 10% (Gammagard®)		300 mL/hr	350 mL/hr	400 mL/hr	450 mL/hr	500 mL/hr
RX: IVIG _____ Grams _____ Days Infusion Rate: _____ cc/hr for the 1st hr _____ cc/hr for the second hr _____ cc/hr thereafter						
Repeat/Maintenance treatment in: _____ or every _____ / month						
Dose: _____ Frequency: _____ Start Date: _____ Duration: _____						
Hypersensitivity Anaphylaxis Management						
Vital Signs: <input checked="" type="checkbox"/> Vital signs every 2 minutes until stable. Then, every 5 minutes for 30 minutes, then every 15 minutes until hypersensitivity/anaphylaxis reaction subsides.		Assessments: <input checked="" type="checkbox"/> Stop the administration of any agent causing hypersensitivity/anaphylaxis reaction immediately. <input checked="" type="checkbox"/> Remain with patient, maintain airway and perform CPR if necessary.		Interventions: <input checked="" type="checkbox"/> Lay patient supine with legs elevated IMMEDIATELY <input checked="" type="checkbox"/> Oxygen therapy at 8-10 LPM via face mask		
<input checked="" type="checkbox"/> Albuterol nebulization 2.5mg/3.0mL once for hypersensitivity/anaphylaxis reaction		<input checked="" type="checkbox"/> Glucagon 1 mg IV if on Beta Blockers once PRN, if patient on beta blockers and fails to respond to initial treatment		<input checked="" type="checkbox"/> Sodium chloride 0.9% bolus and infusion <input checked="" type="checkbox"/> Sodium chloride (NORMAL SALINE) 0.9 % bolus 1,000 mL, 1,000 mL, IV, once, for 30 minutes		
<input checked="" type="checkbox"/> Epinephrine 1:1000 (1mg/mL) injection 0.3 mg, Intramuscular, once PRN for hypersensitivity/anaphylaxis reaction. May repeat every 5-10 minutes x 3 doses. If not effective, then may give epinephrine 0.5 mg IM. Epinephrine should be administered first, as soon as the diagnosis of anaphylaxis is suspected.		<input checked="" type="checkbox"/> Epinephrine 1:1000 (1mg/mL) injection 0.5 mg, Intramuscular, once PRN for severe cases of hypersensitivity/anaphylaxis reaction. May repeat every 5-10 minutes Epinephrine should be administered first as soon as the diagnosis of anaphylaxis is suspected.		<input checked="" type="checkbox"/> Diphenhydramine injection 50 mg IV push once PRN over 1-2 minutes for hypersensitivity/anaphylaxis reaction (25 mg/min maximum).		
<input checked="" type="checkbox"/> Epinephrine 1:1000 (1mg/mL) injection 0.01 mg/kg Intramuscular, once PRN for patients who weigh less than 30 kg for hypersensitivity/anaphylaxis reaction. May repeat every 5-10 minutes Epinephrine should be administered first as soon as the diagnosis of anaphylaxis is suspected.		<input checked="" type="checkbox"/> Loratadine 10 mg PO once for hypersensitivity/anaphylaxis reaction		<input checked="" type="checkbox"/> Methylprednisolone injection 125 mg IV once for hypersensitivity/anaphylaxis reaction		
<input checked="" type="checkbox"/> Prednisone 60 mg PO once for hypersensitivity/anaphylaxis reaction		<input checked="" type="checkbox"/> Hydrocortisone injection 100 mg IV over 30-60 seconds once PRN for hypersensitivity/anaphylaxis reaction		<input checked="" type="checkbox"/> Famotidine 20 mg PO once PRN for hypersensitivity/anaphylaxis reaction		
<input checked="" type="checkbox"/> Famotidine 20 mg PO once PRN for hypersensitivity/anaphylaxis reaction		<input checked="" type="checkbox"/> Famotidine 20 mg IV push over 2 minutes once PRN for hypersensitivity/anaphylaxis reaction				
Notes						
Physician Information						
Prescriber name:		Phone:		Office contact name:		
Prescriber address:		City:		State: Zip:		
NPI:	DEA:	Fax and/or Email:				
Prescriber signature:		Date:		<input type="checkbox"/> DO NOT SUBSTITUTE		

Important Notice: This facsimile transmission is intended to be delivered only to the named recipient(s), and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named recipient, immediately notify the sender at the address and phone number set forth herein and obtain instructions as to properly dispose of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except authority of the sender to the named addressee.