# 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:** ☐ F ☐ M | **HT:** | **WT:** |
| **Address:** | **City:** | **State:** | **Zip Code:** | **Phone:** |
| **Insurance:** | **Subscriber's name:** | **ID#:** | | **Group #:** |

**Allergies:** ☐ NKDA ☐ 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:** ☐ Idiopathic Thrombocytopenic Purpura ☐ Primary Immunodeficiency Syndrome ☐ Chronic Inflammatory Demyelinating Polyneuropathy ☐ Other (specify):

**Vital Signs:** ☐ Monitor BP q15min for the first hr of initial infusion, then q30-60min for the remainder of IVIG infusion ☐ Monitor BP q30-60min for subsequent IVIG infusions

**Notify Physician if any of the following are observed:** ☐ SBP is less than 90 mmHg or greater than 180 mmHg ☐ DBP is less than 50 mmHg or greater than 90 mmHg ☐ Temperature is greater than 101.5 degrees F ☐ Heart Rate is less than 50 or greater than 120 ☐ RR is less than 10 or greater than 30 respirations/min ☐ Urine Output is less than 30 mL/hr or 240 mL/shift ☐ Pulse Oximetry is less than 90% ☐ 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:** ☐ Acetaminophen 650 mg po one time 30-60 min prior to each dose of IVIG ☐ Diphenhydramine 25 mg po one time prn 30-60 min prior to each dose of IVIG ☐ Other:

**Immune Globulin:** ☐ Predisposed to renal insufficiency, minimize rate of infusion ☐ 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.
☐Patient has been previously treated with IVIG and tolerated therapy ☐ Patient has NOT been previously treated with IVIG ☐ Pharmacist to use current weight for dose calculations ☐ Use (specify): _____ kg as dosing weight ☐ 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 10% (Privigen®) | 140 mL/hr | 165 mL/hr | 190 mL/hr | 215 mL/hr | 240 mL/hr |
| Sucrose Free 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

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|---|---|---|
| **Vital Signs:** ☒ Vital signs every 2 minutes until stable. Then, every 5 minutes for 30 minutes, then every 15 minutes until hypersensitivity/anaphylaxis reaction subsides. | **Assessments:** ☒ Stop the administration of any agent causing hypersensitivity/anaphylaxis reaction immediately. ☒ Remain with patient, maintain airway and perform CPR if necessary. | **Interventions:** ☒ Lay patient supine with legs elevated IMMEDIATELY ☒ Oxygen therapy at 8-10 LPM via face mask |
| ☒ Albuterol nebulization 2.5mg/3.0mL once for hypersensitivity/anaphylaxis reaction | ☒ Glucagon 1 mg IV if on Beta Blockers once PRN, if patient on beta blockers and fails to respond to initial treatment | ☒ Sodium chloride 0.9% bolus and infusion ☒ Sodium chloride (NORMAL SALINE) 0.9 % bolus 1,000 mL 1,000 mL, IV, once, for 30 minutes |

| | |
|---|---|
| ☒ 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. | ☒ 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. |
| ☒ 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. | ☒ Diphenhydramine injection 50 mg IV push once PRN over 1-2 minutes for hypersensitivity/anaphylaxis reaction (25 mg/min maximum). |
| ☒ Loratadine 10 mg PO once for hypersensitivity/anaphylaxis reaction | ☒ Methylprednisolone injection 125 mg IV once for hypersensitivity/anaphylaxis reaction |
| ☒ Prednisone 60 mg PO once for hypersensitivity/anaphylaxis reaction | ☒ Hydrocortisone injection 100 mg IV over 30-60 seconds once PRN for hypersensitivity/anaphylaxis reaction |
| ☒ Famotidine 20 mg PO once PRN for hypersensitivity/anaphylaxis reaction | ☒ 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:** | ☐ **DO NOT SUBSTITUTE** | |