

Immune Deficiency Immunoglobulin Therapy

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|--------------|--------|---------------------------------|--|
| To | From | Number of Pages including Cover | |
| Intake Phone | Phone | Fax | |
| Patient Name | DOB | Date | |
| Allergies | Height | Weight | |

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 SCIG using _____ sites at a time. Repeat _____ week(s). Ok to round dose to nearest vial size. Refill x 1yr.

| Diagnosis | ICD-10 | Diagnosis | ICD-10 |
|---|--------|---|--------|
| Common Variable Immunodeficiency with Predominant Immunoregulatory T-Cell Disorders | D83.1 | Selective deficiency of Immunoglobulin M [IgM] | D80.4 |
| Wiskott-Aldrich Syndrome | D82.0 | Selective deficiency of Immunoglobulin G [IgG] Subclasses | D80.3 |
| Combined Immunodeficiency, Unspecified | D81.9 | Hereditary Hypogammaglobulinemia | D80.0 |
| Severe Combined Immunodeficiency [SCID] with Low T- and B- Cell Numbers | D81.1 | Immunodeficiency with Increased IgM | D80.5 |
| Severe combined Immunodeficiency [SCID]with Low or Normal B-Cell Numbers | D81.2 | Other Common Variable Immunodeficiencies | D83.8 |
| Selective deficiency of Immunoglobulin A [IgA] | D80.2 | Common Variable Immunodeficiency, Unspecified | D83.9 |

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.

Medi-Cal ID#

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

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature: _____
Date: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

The attached document(s) contain confidential information which may be considered to be Protected Health Information and therefore required to be maintained as private and secure under HIPAA. The documents may also contain information which is otherwise considered to be privileged under state and federal laws. This communication is for the intended recipient only. If you are not the intended recipient, or a person responsible for delivering this communication to the intended recipient, you are prohibited from viewing, copying and/or distributing the information contained herein. Unlawful disclosure of the information attached may subject you to monetary penalties and sanctions. If you have received this communication in error, you should notify the sender immediately and thereafter permanently destroy all copies of this document in its entirety.

This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.

This is not a valid prescription in the state of Arizona.