

IMMUNE DEFICIENCY PRESCRIPTION FORM

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Patient Information

Name:			Parent/Guardian (if applicable):		
DOB:	Height:	Weight:	Phone:	Email:	
Address:			City, State, Zip:		
Male	Female	First Dose of IVIG:	YES	NO	Prior IG Brands Used:
Specific Adverse Reaction w/ Prior Brands:					
Allergies:					

Diagnosis

Combined Immunodeficiency, Unspecified **D81.9** Hereditary Hypogammaglobulinemia **D80.0** Other Combined Immunodeficiencies **D81.89**
Common Variable Immunodeficiency, Unspecified **D83.9** Immunodeficiency w/Increased IgM **D80.5** Other: _____
CVID w/Predominant Immunoregulatory T-Cell Disorders **D83.1** Nonfamilial Hypogammaglobulinemia **D80.1**

Prescription Information

Product: Pharmacist to Determine Physician Branded: _____

<input type="checkbox"/> Intravenous Immunoglobulin Recommended dose 0.4 – 0.8 gm/kg Infuse: _____ gm/kg Infuse: IV daily over _____ days; repeat every _____ weeks; _____ months Other: _____	<input type="checkbox"/> Subcutaneous Immunoglobulin Pharmacy to determine # of sites unless alt # of sites indicated here: _____ Infuse: _____ grams subcutaneously ; _____ times; _____ weeks; _____ months Other: _____
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Infusion Rate: Please select one and provide complete information
Pharmacist to determine per manufacturer recommendations
Start at _____ mL/hour then increase by _____ mL/hour every _____ minutes to maximum rate _____ mL/hour

IV Access: Peripheral PICC Port Other: _____

IV Maintenance (Flushing): Dispense quantity sufficient
Sodium chloride 0.9% 10mL prefilled syringe: flush IV access device with sodium chloride 1-10mL to maintain line patency
Heparin 100 units/mL 5mL prefilled syringe: flush with 100 units/mL 3-5 mL as needed to maintain line patency

Pretreatment: Dispense quantity sufficient
Acetaminophen 325mg tablet: 1-2 tablets by mouth 15-30 minutes before each infusion
Diphenhydramine 25mg capsule: 1-2 capsules by mouth 15-30 minutes before each infusion
Other: _____

Ancillary Supplies: Dispense ancillary supplies and equipment needed to provide home infusion therapy Refills: _____

Labs: Labs will not be drawn on weekends/holidays. Not for STAT labs.
Labs to be drawn: _____ Frequency of labs: _____

Adverse/Anaphylactic Reactions: Anaphylaxis kit to be used in the event of anaphylactic reaction and includes the below components:
Diphenhydramine 25mg capsule (qty 2), Diphenhydramine 50mg/mL 1mL vial (qty 1), Epinephrine injection auto-injector 0.3mg (>30kg pt) or 0.15mg (<30kg pt) (qty 1 two-pack), Sodium chloride 0.9% 500mL bag (qty 1), and Sodium chloride 0.9% 10mL prefilled syringe (qty 4)

Nursing Orders: Nurse to administer IVIG and ancillary medications per orders. Skilled nursing visits for education of SCIG administration (not applicable if independent with therapy)

Physician Information

Physician:		Office Contact:	
Address:		City, State, Zip:	
Phone:	Fax:	License:	NPI:

Number of Drugs Prescribed: _____ (Prescription is void if number of drugs are not indicated. Regulation 16 CCR 1717.3)

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Prescriber's Signature:	Date:
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