

IMMUNE GLOBULIN (PEDIATRICS) PRESCRIBER ORDER FORM

Patient Name:

Date of Birth:

Address:

Phone:

Height:

 inches cm

Weight:

 lbs kg**Clinical Information**

Primary Diagnosis Description:

ICD-10 Code:

Immune Globulin Prescription

Immune globulin refill as directed x 1 year

Loading Dose: _____Maintenance Dose: IV Subcutaneous Infuse _____ gm daily for ____ day(s) every ____ week(s) Infuse _____ gm/kg (BMI > 30, adjusted body weight used) divided over ____ day(s) every ____ week(s) Other: _____

Pharmacist to identify clinically appropriate IG brand and infusion rates. May substitute product based on product availability.

Infuse entire contents of IG infusion bag/vial(s) per current dose. May infuse +/- 4 days to allow for patient scheduling

Round dose to the nearest single-use vial size.

Ancillary Orders**Anaphylaxis Orders**

- IV Doses:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SubQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
 - Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg - 25mg max per dose) IV or IM; repeat x 1 in 15 min PRN no improvement.
 - 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.
- SUBQ Doses: Epinephrine Auto-Injector 0.3 mg (≥ 30 kg) or 0.15 mg (15 to 30 kg) 2-Pack – Inject 1 dose IM x 1 PRN anaphylactic reaction, repeat x1 PRN.

Pre-Medication and/or Laboratory Orders

- Acetaminophen _____ mg PO 30 min before infusion. Patient may use own supply or patient may decline.
- Diphenhydramine _____ mg PO 30 min before infusion. Patient may use own supply or patient may decline.
- Other: _____
- Other: _____

IV Flush Orders

- Peripheral: 0.9% Sodium Chloride 1 mL (2 to 20 kg) or 1 to 3 mL (> 20 kg) pre-/post-use and 1 to 3 mL (2 to 20 kg) or 3 to 5 mL (> 20 kg) pre-/post-lab draw. Heparin (10 unit/mL) 1 mL (2 to 20 kg) or 1 to 3 mL (> 20 kg) post-use.
- Implanted Port: 0.9% Sodium Chloride 1 to 3 mL pre-/post-use and 3 to 5 mL pre-/post-lab draw. Heparin (10 unit/mL) 3 to 5 mL post-use.

For maintenance, heparin (10 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Skilled nurse to administer doses intravenously where applicable. Skilled nurse to assess and teach self-administration of SUBQ medication where appropriate.

Nurse will provide ongoing support, including administration of medication, PRN. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature:

Date:

Prescriber Information

Prescriber Name:

Phone:

Fax:

Address:

NPI:

City, State:

Zip:

Office Contact:

Fax completed form, insurance information, and clinical documentation to:

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