



SPECIALTY INFUSION

IMMUNE GLOBULIN AUTOIMMUNE DISORDER

toll free fax 866.794.4844 toll free 866.202.9552

krogerspecialtyinfusion.com

KROGER SPECIALTY INFUSION REPRESENTATIVE: _____

PATIENT INFORMATION

Patient Name		Parent/Guardian (if applicable)		<input type="checkbox"/> All Insurance Info Attached
Address		City	State	Zip
Main Phone	Alternate Phone	Email Address		
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height (required) inches	Weight (required) pounds	
Other Drugs Used to Treat Patient's Condition		First Dose of IVIg: <input type="checkbox"/> Yes <input type="checkbox"/> No	Prior Ig Products Tried	
Adverse Reactions with Previous Ig Treatments		Allergies		

CLINICAL INFORMATION - PRIMARY DIAGNOSIS - ICD-10

<input type="checkbox"/> Acute Infective Polyneuritis (Guillain-Barre Syndrome)	ICD-10 _____	<input type="checkbox"/> Myasthenia Gravis without (Acute) Exacerbation	ICD-10 _____
<input type="checkbox"/> Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	ICD-10 _____	<input type="checkbox"/> Pemphigus (Pemphigus Foliaceus, Pemphigus Vulgaris)	ICD-10 _____
<input type="checkbox"/> Dermatomyositis	ICD-10 _____	<input type="checkbox"/> Pemphigoid	ICD-10 _____
<input type="checkbox"/> Inflammatory Polyneuropathy, Unspecified	ICD-10 _____	<input type="checkbox"/> Polymyositis	ICD-10 _____
<input type="checkbox"/> Multiple Sclerosis (MS)	ICD-10 _____	<input type="checkbox"/> Stiff-Person Syndrome	ICD-10 _____
<input type="checkbox"/> Multifocal Neuropathy (MMN)	ICD-10 _____	<input type="checkbox"/> Other: _____	ICD-10 _____
<input type="checkbox"/> Myasthenia Gravis with (Acute) Exacerbation	ICD-10 _____		

PRESCRIPTION AND ORDERS

Administer: SCIG IMIG Product: Pharmacist to determine (or) Formulation: _____

Dose: (please select option(s) and provide complete information, pharmacy to round the nearest 5 gram vial)

Loading Dose: _____ gm/kg OVER _____ day(s), then Maintenance Dose: _____ gm/kg OVER _____ day(s) EVERY _____ week(s) x _____ cycle(s)

Other Regimen: _____

Infusion Rate: (please select one and provide complete information)

Pharmacist to determine

Start at _____ mL/hr, then increase by _____ mL/hr every _____ minutes to maximum rate _____ mL/hr

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 3-10mL to maintain line patency.
- Heparin 10 units/mL 5mL Prefilled Syringe: Flush peripheral IV access device with Heparin 10 units/mL 1-5 mL as needed to maintain line patency.
- Heparin 100 unit/mL 5mL Prefilled Syringe: Flush central IV access device with Heparin 100 units/mL 3-5 mL as needed to maintain line patency.

Adverse/Anaphylactic Reactions: Anaphylaxis kit to be used in the event of anaphylactic reaction and will contain the following:

- Diphenhydramine 25mg Capsule #2
- Diphenhydramine 50mg/mL 1mL vial #1
- Sodium Chloride 0.9% 500mL Bag #1
- Epinephrine Injection Auto-Injector 0.3mg (>30kg pt) or 0.15mg (<30kg pt) Two-Pack #1
- Sodium Chloride 0.9% 10mL Prefilled Syringe #4

Pre-Treatment: Dispense Quantity Sufficient

Acetaminophen 325mg Tablet: 1-2 tablets by mouth 15-30 minutes before each infusion. Decline

Diphenhydramine 25mg Capsule: 1-2 capsules by mouth 15-30 minutes before each infusion. Decline

Other: _____

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

Labs: Results will be faxed to physician's office. If no frequency noted, ordered labs to be done prior to initial infusion only. Labs will not be drawn on weekends or holidays. Not appropriate for STAT labs.

Labs to be Drawn: _____ Frequency of Labs: _____

PHYSICIAN INFORMATION

Physician Name: _____ License: _____

Address: _____ DEA: _____

City: _____ State: _____ Zip: _____ NPI: _____

Phone: _____ Fax: _____ Office Contact (required): _____

By signing this form and utilizing our services, you are authorizing Kroger Specialty Infusion and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date

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Nursing Orders for Home Infusion MONITOR (IV Only)

Observe: Vital signs prior to infusion. Blood pressure and pulse every 15 minutes for first hour, then every 30 minutes until stable infusion rate, then every hour.

Watch for: Signs of fluid overload, cardiovascular symptoms, allergic reactions, skin rash, fever, and moderate to severe headache.

Call/Page MD: For adverse events, stop the infusion. Can restart the infusion at the same or lower rate pending physician's approval or if symptoms subside.