



SPECIALTY INFUSION

# IMMUNE GLOBULIN MATERNAL FETAL MEDICINE

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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 Administered
Adverse Reactions with Previous Ig Treatments		Allergies	

## CLINICAL INFORMATION-PRIMARY DIAGNOSES ICD-10

- Neonatal Alloimmune Thrombocytopenia ICD-10 \_\_\_\_\_  Rh Sensitization or Severe Isoimmunization ICD-10 \_\_\_\_\_  
 Idiopathic Thrombocytopenia Purpura ICD-10 \_\_\_\_\_  Neonatal Hemochromatosis ICD-10 \_\_\_\_\_

## PRESCRIPTION AND ORDERS

### Immune Globulin Order:

Dose: \_\_\_\_\_ g/kg over \_\_\_\_\_ day(s) OR \_\_\_\_\_ g over \_\_\_\_\_ day(s). Interval (frequency of therapy): \_\_\_\_\_ Refills: x \_\_\_\_\_

Administer:  IVIG Product:  Pharmacist to determine (or)  Formulation: \_\_\_\_\_

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: \_\_\_\_\_

### 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.

## PHYSICIAN INFORMATION

Physician Name: _____	License: _____
Address: _____	DEA: _____
City: _____ State: _____ Zip: _____	NPI: _____
Phone: _____ Fax: _____	Office Contact (required): _____
Referral Date: _____	Referred By (name): _____
Referral Time: _____	Phone/Extension: _____

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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