Kroger specialty infusion

toll free fax 866.794.4844

Immune Globulin Primary Immune Deficiency

Torrance, CA toll free 866.202.9552 krogerspecialtyinfusion.com

Kroger Specialty Infusion Representative:

Patient Information

Patient Name		Parent/Guardian Name (if applicable) ☐ All Insurance Info Attached	
Address		City State Zip	
Main Phone	Alternate Phone	Email	
Date of Birth	☐ Male ☐ Female	Weight (required) ☐ kg ☐ lbs	Height (required) ☐ ft ☐ in
Other Drugs Used to Treat Patient's Condition		First Dose of IVIg: ☐ No ☐ Yes	Prior Ig Products Tried
Adverse Reactions with Previous Ig Treatments		Allergies	

Clinical Information - Primary Diagnosis - ICD-10

☐ Common Variable Immunodeficiency (CVID)	ICD-10: _____	☐ Immunodeficiency with Increased IgM	ICD-10: _____
☐ Combined Immunity Deficiency & SCID	ICD-10: _____	☐ Selective IgM Immunodeficiency	ICD-10: _____
☐ Congenital Hypogammaglobulinemia	ICD-10: _____	☐ Selective Ig Immunodeficiency	ICD-10: _____
☐ Hypogammaglobulinemia	ICD-10: _____	☐ Other: _____	ICD-10: _____

Prescription and Orders

Administer: ☐ SCIG ☐ IVIG **Access:** ☐ Peripheral ☐ PICC ☐ Port ☐ Other: _____

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

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 units/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
- Epinephrine Injection Auto-Injector 0.3mg (>30kg pt) or 0.15mg (<30kg pt) Two-Pack #1
- Sodium Chloride 0.9% 500mL Bag #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/holidays. Not appropriate for STAT labs.

Labs to be Drawn: _____ Frequency of Labs: _____

Nursing Orders: Skilled Home Infusion Nursing to Administer IVIg as Outlined in MD Order
- ***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.

Skilled RN: To teach/train to administer SQ via pump with necessary supplies for each subcutaneous infusion up to 3 visits. RN to notify pharmacy directly if patient is unable to self-administer.

Physician Information

Physician Name	DEA #	NPI #	License #
Address	City State Zip		
Phone / Fax	Office Contact (required)		

By signing this form, you are authorizing Kroger® Specialty Infusion and its employees to serve as your designated agent in submitting clinical and other required information to third party payors with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Prescriber's Signature (no stamps) Substitution Permitted _____ Date _____

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