# IMMUNE GLOBULIN PRIMARY IMMUNE DEFICIENCY

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)* | ❑ All Insurance Info Attached |
| Address | | City | State / Zip |
| Main Phone | Alternate Phone | Email Address | |
| Date of Birth | ❑ Male ❑ Female | Height *(required)* inches | Weight *(required)* pounds |
| Other Drugs Used to Treat Patient's Condition | | First Dose of IVIg: ❑ Yes ❑ No | 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 **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: ______________________

**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)*: ______________________

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

**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 addresses 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.

04952 11-15-2018 TCA