SPECIALTY INFUSION

POST-INFECTIOUS NEUROPSYCHIATRIC DISORDER

Torrance, CA **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

❑ **D83.9** CVID ❑ **G04.01** Post-infectious encephalitis ❑ **I02.9** Sydenham's chorea ❑ **M35.9** Autoimmune disease

❑ **G04.81** Other encephalitis and encephalomyelitis

❑ **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)*

❑ **IVIG:** 2 g/kg (max 70 g) OVER _______ day(s) EVERY _______ week(s) x _______ cycle(s)

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❑ **IVIG:** _______ once daily for _______ day(s) EVERY _______ week(s) x _______ cycle(s)

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 _____mg orally pre-IVIG, 30 minutes before each infusion and every 6 hours as needed for fever/headache/chills. Max _____mg/24 hours. ❑ Decline

Diphenhydramine _____mg orally pre-IVIG, 30 minutes before each infusion, and every 6 hours as needed for chills/rash/itching. ❑ Decline

Ibuprofen _____mg orally 30 minutes before each infusion and every 8 hours as needed for mild-moderate pain. Only dispense on days Methylprednisolone not given. ❑ Decline

Lidocaine/Prilocaine 2.5%/2.5% cream 30 g. Apply to IV site 15 minutes prior to access as needed. ❑ Decline

Methylprednisolone _____mg to be diluted with pre-hydration before each infusion. Max 1g/24 hours. ❑ Decline

Ondansetron _____mg orally 30 minute before each infusion and every 8 hours as needed for nausea/vomiting. Max 8mg/dose. ❑ Decline

Ranitidine _____mg orally 30 minutes prior to Methylprednisolone infusion and every 12 hours while on Methylprednisolone. Max 300mg/24 hours. ❑ Decline

Sodium Chloride 0.9% _____mL bolus pre and post-IVIG infusion. Infuse as tolerated (rate per pharmacy). ❑ 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 it's 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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