SPECIALTY INFUSION

IMMUNE GLOBULIN AUTOIMMUNE DISORDER

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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

❏ Acute Infective Polyneuritis (Guillain-Barre Syndrome)	ICD-10 ________	❏ Myasthenia Gravis without (Acute) Exacerbation	ICD-10 ________
❏ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	ICD-10 ________	❏ Pemphigus (Pemphigus Foliaceus, Pemphigus Vulgaris)	ICD-10 ________
❏ Dermatomyositis	ICD-10 ________	❏ Pemphigoid	ICD-10 ________
❏ Inflammatory Polyneuropathy, Unspecified	ICD-10 ________	❏ Polymyositis	ICD-10 ________
❏ Multiple Sclerosis (MS)	ICD-10 ________	❏ Stiff-Person Syndrome	ICD-10 ________
❏ Multifocal Neuropathy (MMN)	ICD-10 ________	❏ Other: ______________________	ICD-10 ________
❏ Myasthenia Gravis with (Acute) Exacerbation	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.
❏ Quantitative Ig A prior to first dispense. Pharmacist to obtain authorization from MD. ❏ Other: __________ 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

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