BIG SKY IV CARE
Infusion Pharmacy & Nursing
An Access Infusion Care Company

INTRAVENOUS IMMUNOGLOBULIN ORDERS

REFERRAL CHECKLIST
Please ensure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ CBC w/diff/CMP/Quantitative immunoglobulins/lymphocyte subset panel (if applicable to dx)
☐ Completed and Signed Referral
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

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Print, complete, and fax completed form to (406) 752-0443

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INTRAVENOUS IMMUNOGLOBULIN ORDERS

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Ht: Wt: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ **New Referral** ☐ **Continuation Order** ☐ **Dose or Frequency Change**

First dose? ☐ Yes ☐ No - Date of last infusion:

Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other:

DIAGNOSIS

☐ Dx Code/description:

REQUIRED DOCUMENTATION ☐ **Signed order** ☐ **Demographics/insurance info** ☐ **H&P/labs/tests/progress notes supporting the Dx**

Prior Therapies:

PRESCRIBING INFORMATION

LAB ORDERS

Frequency: Every Labs: ☐ CMP ☐ CBCwdif ☐ CRP ☐ Sed Rate ☐ Quantitative immunoglobulins ☐ Lymphocyte subset panel ☐ Other:

PREMEDICATIONS (administer 30 minutes prior to infusion)

Acetaminophen: ☐ 650mgPO ☐ 1000mgPO	Methylprednisolone: ☐ 100mgIV ☐ 125mgIV ☐ mgIV
Diphenhydramine: ☐ 25mgPO ☐ 50mgPO ☐ 25mgIV ☐ 50mgIV	Other: ☐

MEDICATION

Medication	Dose/Strength	Directions	Quantity
☐ **Gammagard Liquid 10%** ☐ **Gamunex-C 10%** ☐ **Privigen 10%** ☐ **Other:** ☐ **Octagam 10%** ☐ **No Product Preference**	☐ Gm ☐ mg/kg	☐ x day(s) every weeks ☐ divided over days every weeks ☐ Infuse IV as directed per the PI and as tolerated	☒ # vials sufficient for dose Refills:

HYDRATION

Pre-Infusion: Fluid- ☐ 0.9%NS ☐ Other: Volume- ☐ 250ml ☐ 500ml ☐ 1000ml

Post-Infusion: Fluid- ☐ 0.9%NS ☐ Other: Volume- ☐ 250ml ☐ 500ml ☐ 1000ml

If no product preference, pharmacist to select product based on payor requirements/availability/indication unless otherwise noted.
Use current documented weight;
Round calculated dose to nearest dose achievable using whole vials of one available vial size within ±10% of calculated dose.
If not specified, order will be valid for 1 year from the date of signature.

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:Use 50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain SpO_2 95-100%.

Prescriber Signature X: _____ **Date:** _____

☐ **Product Substitution Permitted** ☐ **Dispense as Written**

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