Dermatology IVIG Patient Referral Form

Return Signed Rx via fax to (800) 878-4160

Date	Fax #	# of Pages
Contact		Phone #
Patient's Name	Height	Weight

Rx: Intravenous Route (*Dose will be rounded to nearest vial size*)

❒ Pharmacy Select ❒ Specify Brand:_____

_____ grams **OR** _____ grams per kg **OR**_____ mg per kg

Every _____ weeks

❒ Divide total dose over _____ days

❒ Refill for _____ months.

Rx: Subcutaneous Route (*Dose will be rounded to nearest vial size*)

❒ Pharmacy Select ❒ Specify Brand:_____

_____ grams **OR** _____ grams per kg **OR**_____ mg per kg

❒ Once weekly ❒ Every 2 weeks ❒ Other_____

❒ Refill for _____ months.

Diaganosis

❒ L12.1 Cicatricial Pemphigoid
❒ L12.0 Bullous Pemphigoid
❒ L10.0 Pemphigus Vulgaris
❒ M33.90 Dermatopolymyositis, unspecified
❒ M33.20 Polymyositis, organ involvement, unspecified
❒ M33.12 Other Dermatopolymyositis with myopathy
❒ M33.92 Dermatopolymyositis, unspecified with myopathy
❒ Other: _____

ANAPHYLAXIS KIT ☑ Maintain anaphylaxis kit in the home per Vital Rx policy

INFUSION PROTOCOL

-Begin infusion at 35 ml/hr and increase rate and infuse IV as patient tolerates based on the following:

30 grams or less: Over 2 - 4 hours or as tolerated
30 - 50 grams: Over 2 - 6 hours or as tolerated
50 grams: Over 4 - 8 hours or as tolerated

-Pre-medicate before every dose of IVIG with:

❒ Acetaminophen 650 mg PO
❒ Diphenhydramine 25 - 50 mg PO or by SLOW IV Push over 3 - 5 minutes PRN

-OPTIONAL Pre-medications (mark all that apply)

❒ Solumedrol 100 mg IV by SLOW IV PUSH over 3 - 5 minutes
❒ Famotidine 20 mg by SLOW IV PUSH over 3 - 5 minutes
❒ HYDRATE with 500 - 1000ml Normal Saline IV or D5W

CATHETER TYPE

❒ PIV
❒ PORT (may use PIV if needed)

CATHETER CARE AND FLUSHING ORDERS:

-Sodium Chloride
5-10 ml before & after each IV medication and PRN

-Heparin
100 u/ml: 5 ml following 2nd saline flush & PRN

-Sterile Saline
10 ml to access PORT PRN

LAB ORDERS

❒ If needed, a Basic Metabolic Panel (Chem 7) to be drawn prior to first dose.

NURSING ORDERS

RN to infuse IVIG x _____ days every _____ week(s) and as needed. RN to provide initial education and PRN visits as needed.

If necessary Patient may have first dose administered in the home by a skilled nurse, unless instructed otherwise. Pharmacy to provide all equipment and medical supplies necessary to administer therapy as appropriate.

Prescriber Signature:_____ Date:_____ NPI #_____

Prescriber following patient if different from above:_____

Vital Rx

Phone: (866) 209-5540 | Fax: (800) 878-4160