



Dermatology IVIG Patient Referral Form

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

Date	Fax #	# of Pages
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Contact	Phone #
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Patient's Name	Height	Weight
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Rx: Intravenous Route <i>(Dose will be rounded to nearest vial size)</i> <input type="checkbox"/> Pharmacy Select <input type="checkbox"/> Specify Brand: _____ _____ grams OR _____ grams per kg OR _____ mg per kg Every _____ weeks <input type="checkbox"/> Divide total dose over _____ days <input type="checkbox"/> Refill for _____ months.	Rx: Subcutaneous Route <i>(Dose will be rounded to nearest vial size)</i> <input type="checkbox"/> Pharmacy Select <input type="checkbox"/> Specify Brand: _____ _____ grams OR _____ grams per kg OR _____ mg per kg <input type="checkbox"/> Once weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Other _____ <input type="checkbox"/> Refill for _____ months.
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Diagnosis <input type="checkbox"/> L12.1 Cicatricial Pemphigoid <input type="checkbox"/> L12.0 Bullous Pemphigoid <input type="checkbox"/> L10.0 Pemphigus Vulgaris <input type="checkbox"/> M33.90 Dermatopolyomyositis, unspecified	<input type="checkbox"/> M33.20 Polymyositis, organ involvement, unspecified <input type="checkbox"/> M33.12 Other Dermatopolyomyositis with myopathy <input type="checkbox"/> M33.92 Dermatopolyomyositis, unspecified with myopathy <input type="checkbox"/> Other: _____
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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: <input type="checkbox"/> Acetaminophen 650 mg PO <input type="checkbox"/> Diphenhydramine 25 - 50 mg PO or by SLOW IV Push over 3 - 5 minutes PRN -OPTIONAL Pre-medications (mark all that apply) <input type="checkbox"/> Solumedrol 100 mg IV by SLOW IV PUSH over 3 - 5 minutes <input type="checkbox"/> Famotidine 20 mg by SLOW IV PUSH over 3 - 5 minutes <input type="checkbox"/> HYDRATE with 500 - 1000ml Normal Saline IV or D5W	CATHETER TYPE <input type="checkbox"/> PIV <input type="checkbox"/> 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: _____

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Vital Rx
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