CALIFORNIA SPECIALTY™ PHARMACY

# Patient Referral Form IG Orders (Autoimmune)

**CSP Representative:**

***Physicians must fax the completed referral form to California Specialty Pharmacy at 866-853-6555***

## PATIENT INFORMATION

Ship to: ☐ Physician's Office ☐ Patient's Home

Date: _____

Patient name: _____

Address: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

IV Access: ☐ Peripheral ☐ PICC ☐ Port ☐ Central Line ☐ Other: _____

Allergies: _____ ☐ NKDA

Requested Start of Care Date: _____

Date of birth : _____

State of residence: _____

Height: _____ Weight: _____ ☐ lb ☐ kg

ICD-10: _____ BSA_____

ICD-10: _____

Pump Requested: ☐ Yes ☐ No

## IMMUNE GLOBULIN ORDERS (DOSES WILL BE ROUNDED TO THE NEAREST 5 GM VIAL)

**Treatment Naive**: ☐ Yes ☐ No Prior Ig Products Tried: _____

**Loading Dose**: ☐ Yes ☐ No

IVIG: Administer _____ total grams over _____ days **OR** IVIG: Administer _____ grams/kg over _____ days

**Maintenance Dose**:

IVIG: Administer _____ total grams over _____ days **OR** IVIG: Administer _____ grams/kg over _____ days

**Other Regimen**: _____

☐ **Pharmacy to select brand** ☐ **Dispense as written** *(Select one brand below)*

**20%** ☐ Panzyga

**10%** ☐ Gammagard ☐ Gammaked ☐ Gammaplex ☐ Gamunex C ☐ Flebogamma DIF ☐ Octagam ☐ Privigen ☐ Asceniv

**5%** ☐ Gammaplex ☐ Flebogamma DIF ☐ Octagam

Repeat every _____ ☐ weeks _____ ☐ months for a total of _____ courses (+/- _____ days for scheduling flexibility)

**Infusion Rate:** (Please select one and provide complete information). ☐ Physician to determine ☐ Pharmacist to determine

____ml/hr ____minutes; if tolerated, then ____ml/hr ____minutes; if tolerated, then ____ml/hr ____minutes; if tolerated, then ____ml/hr ____minutes; if tolerated then ____ml/hr remainder of the infusion

## PREMEDICATION ORDERS / OTHER ORDERS ☐ DECLINE

| | |
|---|---|
| ☐ Anti-histamine - sedating | ☐ Diphenhydramine 25mg to 50 mg orally 30 - 60 minutes before infusion |
| ☐ Anti-histamine - low/non-sedating | ☐ Loratadine 10 mg orally 30 - 60 minutes before infusion |
| ☐ Analgesic | ☐ Acetaminophen 325mg to 650 mg orally 30 - 60 minutes before infusion |
| ☐ Analgesic - NSAID | ☐ Ibuprofen 400 mg orally 30 - 60 minutes before infusion. May cause GI upset; take with food. |
| ☐ Other Orders: | |

## IV MAINTENANCE (DISPENSE QUANTITY SUFFICIENT)

| | |
|---|---|
| ☐ Sodium Chloride 0.9% PFS 10 mL | ☐ Flush IV access device with sodium chloride 3 –10 mL as needed to maintain patency. |
| ☐ Heparin 10 units/mL 5 mL PFS | ☐ Flush IV access device with Heparin 10 units/mL 1–5 mL as needed to maintain patency. |
| ☐ Heparin 100 units/mL 5 mL PFS | ☐ Flush IV access device with Heparin 100 units/mL 3–5 mL as needed to maintain patency. |
| ☐ EMLA cream 2.5%/2.5% (or generic equivalent) | ☐ Apply topically 30–60 minutes prior to needle insertion as needed for discomfort. |

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| **Patient Name:** | | **State of Residence:** | |
|---|---|---|---|

| **ANAPHYLAXIS ORDERS (DISPENSE QUANTITY SUFFICIENT BASED ON WEIGHT)** | |
|---|---|
| ☐ Sodium Chloride 0.9% 500 mL | Stop IVIG, then start Sodium Chloride 0.9% at KVO or as directed by physician for anaphylactic reaction. |
| ☐Epinephrine Inj 0.3mg/0.3ML (Epi-Pen) | Dosing based on weight, for use in case of anaphylactic reaction. Maximum dose of 0.3 mg. |
| ☐Diphenhydramine 25 mg capsules | Dosing based on weight, for anaphylactic or adverse drug reaction. Maximum dose of 50 mg. |
| ☐Diphenhydramine 50 mg/mL vial | Dosing based on weight. Administer 0.5 to1 ML by slow IV push over 2 minutes for anaphylactic or adverse drug reaction. Maximum dose of 50 mg. |
| ☐Other | |

| **ANCILLARY SUPPLIES AND DME ORDERS (DISPENSE QUANTITY SUFFICIENT)** |
|---|
| Ancillary supplies, including a disposable IV pole, for the infusion of IVIG via peripheral IV, port, or indwelling central catheter via gravity or by ambulatory infusion pump. |

| **NURSING ORDERS** |
|---|
| Nurse to obtain IV access via placement of peripheral IV or insertion of port needle when applicable. If IV access is not obtained after 3 attempts, nurse should contact Pharmacist at CSP for assistance. |
| Nurse to administer IVIG per physician orders. |
| Nurse to monitor vital signs prior to infusion, at every rate change, then every hour after achieving the maximum tolerated rate until the infusion is complete and at the end of the infusion. |
| Nurse to monitor and teach patient to monitor for side effects of IVIG infusion (nausea, vomiting, rash, headache, fever, chills, flu-like symptoms, increases or decreases in blood pressure). Nurse to slow the rate of infusion if patient begins experiencing side effects. If side effects are not resolved with rate reduction, nurse to contact Pharmacist at CSP or physician for further instruction. |
| Nurse to monitor for signs/symptoms of infection (generalized fever and/or malaise, IV site swelling, redness, drainage, warmth or pain). Nurse to notify Pharmacist at CSP or physician for further instruction. |
| Nurse to remove peripheral IV catheter after completion of infusion. May leave peripheral IV or port needle in place for each infusion cycle of therapy. Monitor for signs/symptoms of infection/infiltration. |

| **LAB ORDERS** | |
|---|---|
| *Lab-in-a-Box by HHLA is used for lab draws. Results will be faxed to the office the same day the kit arrives at laboratory (one day after drawn). Labs cannot be drawn on weekends or holidays. Not appropriate for STAT labs.* | |
| Labs to be drawn: | |
| Frequency of labs: | |

| **PHYSICIAN INFORMATION** | | | |
|---|---|---|---|
| Name: | | NPI#: | |
| Phone | | Fax | |

_____ _____

Signature Required Date

Prescription is VOID if the number of drugs prescribed is not noted: _____ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

**Please complete and fax to 866-853-6555**