Immune Globulin Autoimmune Disorder Prescription Form

CIENEGA PHARMACY

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DATE:______________ NEEDS BY DATE:______________ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER ________________________________

PATIENT INFO		PRESCRIBER INFO		
Patient Name		Prescriber Name		
Address		DEA #	NPI #	License #
City, State, Zip		Address		
Main Phone	Alternate Phone	City, State, Zip		
Social Security #		Phone	Fax	
Date of Birth	❑ Male ❑ Female	Contact Person		

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

❑ Acute Infective Polyneuritis (Guillain-Barre Syndrome)	357.0	❑ Myasthenia Gravis with (Acute) Exacerbation	358.01
❑ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	357.81	❑ Myasthenia Gravis without (Acute) Exacerbation	358.0
❑ Dermatomyositis	710.3	❑ Pemphigus (Pemphigus Foliaceus, Pemphigus Vulgaris)	694.4
❑ Unspecified Inflammatory and Toxic Neuropathies (MMN)	357.9	❑ Polymyositis	710.4
❑ Multiple Sclerosis (MS)	340.0	❑ Stiff-Person Syndrome	333.91
		❑ Other: ________________	

PRESCRIPTION AND ORDERS

Administer: ❑ **SCIG** ❑ **IVIG** **Product:** ❑ **Pharmacist to determine** (or) ❑ Formulation ________________

Dose: (please select one and provide complete information)

❑ ____________g daily for____________d ay(s) every____________w eek(s)

❑ ____________________mg/kg every__________week(s)

❑ **Other Regimen :** ________________________________

Refill x 1 year unless noted otherwise

Deliver to: ❑ **Patient's Home** ❑ Physician's Office*

*Physician accepts receipt on behalf of patient

❑ **Nursing for Home Infusion**

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: ____________________

Flushing: Per SASH Protocol (1 mL for peripheral, 5 mL for central/port) 0.9% NaCl, D5W)

Adverse/Anaphylactic Reactions: Anaphylaxis kit will be provided containing:

- Diphenhydramine 25 mg capsules and 50 mg/mL 1 mL vial
- Epinephrine Injection Auto-Injector 0.3mg (>30kg pt) or 0.15mg (<30kg pt) Two-Pack
- 0.9% NaCl Flush
- 0.9% NaCl 500 mL Bag

Pre-Treatment:

Will be sent unless "none" is noted

❑ Acetaminophen 650 mg po 15-30 minutes before the infusion starts — refill x 1 year

❑ Diphenhydramine 25 mg po 15-30 minutes before the infusion starts — refill x 1 year

❑ Aspirin 325 mg po 15-30 minutes before the infusion starts — refill x 1 year

❑ None ❑ Other: ________________________________

MONITOR (IV Only)

Observe: Vital signs prior to infusion. Blood pressure and pulse 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.

Labs:

Results will be faxed to physician's office. If no frequency noted, ordered labs to be done prior to initial infusion only.

❑ BUN/SCr ❑ Q 3 mos. ❑ Q 6 mos. ❑ Q 1 year

❑ Labs to be drawn at physician's office

❑ Other: ____________________

By signing this form, Cienega Pharmacy and it's staff are authorized to serve as your prior authorization designated agent for medical and prescription insurance companies.

______________________ Prescriber's Signature (no stamps) ____________ Date

If Brand required check ❑ DAW

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