BioAccess Pharmacy

Rx Order Form - IVIG

Fax Form to (626) 999-3236

Patient Information	Prescriber Information
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____ Fax: _____
Cell Phone: _____	DEA: _____ NPI #: _____
DOB: _____ Gender: ☐ M ☐ F	Contact Person: _____
Weight: _____lbs.	

Allergies ☐ NKDA ☐ Specify:

Insurance Information

(Please fax a copy of the front and back of all cards)

Primary Insurance:	ID#:		Group:	
Secondary Insurance:	ID#:		Group:	
Prescription Card:	ID#:	BIN#:	PCN#:	Group:

Diagnosis (ICD-10)

(please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization)

☐ D69.3 Idiopathic Thrombocytopenic Purpura	☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy	☐ D83.xx Primary Immunodeficiency Syndrome	☐ Other:

Premedication

Premedication can be given 30-60 minutes prior to infusion:

☐ Acetaminophen PO: ☐ 325mg ☐ 500mg ☐ 650mg

☐ Diphenhydramine: ☐ 25mg IVP ☐ 50mg IVP ☐ 25mg PO ☐ 50mg PO, or ☐ Alternate oral antihistamine:

☐ Cetirizine 10mg ☐ Loratadine 10mg

☐ Methylprednisolone ☐ 125mg IVP ☐ 40mg IVP OR ☐ _____mg PO; ☐ Fexofenadine 60mg, or ☐ 180mg

☐ Others/Miscellaneous: _____

☐ Epinephrine pen Auto-injector 2 pack 0.3mg/0.3ml IM as needed for anaphylaxis

IVIG

Loading Dose IVIG: _____grams. Frequency _____. For _____.

Maintenance Dose IVIG: _____grams. Frequency _____. For _____.

Grams will be rounded down to nearest vial if at least 90% of calculated dose; otherwise rounded up.

☐ Prior IVIG treatment and tolerance.

☐ Ig 0.4g/kg IV daily. Initiate first dose at 15-30 mL/hr and increase rate every 30-60min for duration of infusion. For subsequent doses, titrate every 10-30min to a final max rate listed in infusion table.

☐ Other: _____.

Flushing Protocol:

☐ NaCl 0.9% 5-10ml IV before and after infusion

☐ Heparin 10 units/ml 3-5ml IV after infusion for peripheral/PICC access and PRN

☐ Heparin 100 units/ml 3-5ml IV after infusion for Port IV access and PRN

☐ All infusion supplies necessary to administer the medication

***Skilled Nurse to assess, teach, and administer prescribed medication and admit for services.**

By signing below, I certify that the above therapy is medically necessary and Substitution is authorized unless noted otherwise.

_____ _____ | _____

Provider Signature Date Notes

120 N Fairway Ln Ste A, West Covina, CA 91791 | Ph: 626-999-3636 | Fax: 626-999-3236