vitalcare INFUSION SERVICES

Pharmacy Name: Phone:
Address: Fax:
City/State/Zip: Email:

Immune Deficiency Immunoglobulin Therapy

To	From	Number of Pages including Cover

Intake Phone	Phone	Fax
Patient Name	**DOB**	**Date**
Allergies	**Height**	**Weight**

Rx: Intravenous Route

IVIG _____ grams daily for _____ day(s) OR IVIG _____ grams/kilogram daily given over _____ non-consecutive day(s)
Repeat course every _____ week(s) for a total of _____ course(s) Dose will be rounded to nearest vial size.

Rx: Subcutaneous Route

IG_____ grams each month given as_____ doses OR IG _____ grams _____ times per month. Administer SQIG using _____ sites at a time. Repeat _____week(s). Ok to round dose to nearest vial size. Refill x 1yr.

Diagnosis	ICD-9	ICD-10	Diagnosis	ICD-9	ICD-10
☐ Common Variable Immunodeficiency with Predominant Immunoregulatory T-Cell Disorders	279.10	D83.1	☐ Selective deficiency of Immunoglobulin M [IgM]	276.02	D80.4
☐ Wiskott-Aldrich Syndrome	279.12	D82.0	☐ Selective deficiency of Immunoglobulin G [IgG] Subclasses	279.03	D80.3
☐ Combined Immunodeficiency, Unspecified	279.2	D81.9	☐ Hereditary Hypogammaglobulinemia	279.04	D80.0
☐ Severe Combined Immunodeficiency [SCID] with Low T- and B- Cell Numbers		D81.1	☐ Immunodeficiency with Increased IgM	279.05	D80.5
☐ Severe combined Immunodeficiency [SCID]with Low or Normal B-Cell Numbers		D81.2	☐ Other Common Variable Immunodeficiencies	279.06	D83.8
☐ Selective deficiency of Immunoglobulin A IgA]	279.01	D80.2	☐ Common Variable Immunodeficiency, Unspecified		D83.9
			☐ Other:		

IV Access Device Peripheral Central

Hydration: Infuse 500 ml of NS. Start at 100ml/hr 30 minutes before the IVIG starts; then run concurrently with IVIG infusion.

Medi-Cal ID# Refill x 1Year

Per Home Care Services recommendation:
-ACETAMINOPHEN 650 MG (325mg X 2) orally PRE-IVIG
-DIPHENHYDRAMINE 25 MG orally PRE-IVIG
None
Other premed orders:_____
Other premed orders:_____
Other premed orders:_____
Epi-Pen 0.3mg 2-Pak Auto-Injector

If applicable, flush intravenous access device per Home Care Services protocol:

Access	NS	Heparin 100 u/ml
Peripheral	1 - 3 ml before/after use	1 - 3 ml after last NS
Midline, Central (Non-Port), PICC	3 - 5 ml before/after use 5 - 10 ml after blood draw	3 - 5 ml after last NS
Implanted Port	5 - 10 ml before/after use 10 - 20 ml after blood draw	5 ml after last NS
Groshong PICC, Midline	5 - 10 ml before/after use 10 - 20 ml after blood draw	None

If needed, a Basic Metabolic Panel (Chem 7) to be drawn prior to first dose. 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**
Print Prescriber Name	**NPI#**

Please fax the following information:

- ☐ Immunoglobulin order – include dose, route of administration, frequency, duration, and any pre-medications OR use prescription order section above
- ☐ Patient demographics – include insurance information. **We will obtain authorization** unless the insurance dictates otherwise
- ☐ H & P **OR** progress note(s) describing diagnosis and clinical status
- ☐ Labs – BUN/Creatinine (preferred within last 90 days), Immunoglobulin Panel

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature: _____

Date: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED