COASTAL INFUSION SERVICES

1922 Highway 22 W, Suite A
Madisonville, LA 70447
Local: 985-792-9001

Toll-Free: 833-285-5500
Fax: 985-792-9004
Toll-Free: 833-235-1686

Intravenous Immune Globulin (IVIG) | Order Form

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

1. For new patients, please submit with form:

- Copy of insurance card
- Patient demographics
- Testing results supporting diagnosis
- History & physical
- Labs
- Baseline assessment (include any tried/failed therapies)

2. Patient Information

☐Male ☐Female Height: _____ ☐in ☐cm Weight: _____ ☐lbs ☐kg ☐NKDA Allergies: _____
Has patient been on IG (IV or SQ) before? ☐Yes ☐No If yes, indicate product/relevant information: _____
Date of last IG infusion (if known): _____ Desired start date / next dose due: _____
Line: ☐PIV ☐PICC ☐Port ☐Other: _____ Any additional information: _____

3. Diagnosis and Clinical Information

ICD-10 (required): _____ Primary diagnosis (or check below): _____
☐CIDP ☐Congenital hypogammaglobulinemia ☐CVID ☐Dermatomyositis ☐ITP ☐Guillain-barré syndrome
☐Multifocal motor neuropathy ☐Multiple sclerosis ☐Myasthenia gravis ☐Polymyositis ☐SCID

4. Prescription Information

IVIG Product	☒ IVIG: Pharmacist to select product based on patient specific factors and notify provider of selection or change ☐ Dispense as written, IVIG brand required: _____ Additional information: _____
Dose and Frequency	☐**Loading** dose: _____ ☐grams OR ☐grams/kg, IV divided over ____ day(s) one time ☐**Maintenance**: _____ ☐grams OR ☐grams/kg, IV divided over ____ days(s) every ____ weeks for ____ cycles ☐**Other**: _____ ☒**If weight is >130% ideal body weight (IBW)**, use adjusted body weight (IBW+0.4[ABW-IBW]) to calculate dose Dose to be rounded to whole vial size per Coastal Infusion Services Policy and Procedure unless otherwise indicated
Rate	Infuse IV per manufacturer guidelines OR over _____ hours. Titrate rate according to protocol, as tolerated
Quantity / Refills	☒ Dispense 1 month supply / Refill x 12 months OR ☐Other:_____ ☒ Dispense all medical supplies necessary for infusion

5. Additional Orders

RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per Coastal Infusion Services Policy and Procedure

Premedications: Give 30 min prior to infusions (*Note: if nothing is checked, no premedications will be given*)

Adults (or patients weighing >40kg):

☐Diphenhydramine 25-50mg PO. Patient may decline.
☐Acetaminophen 325-650mg PO. Patient may decline.
☐Methylprednisolone 40mg (OR _____mg) slow IV push (or an equivalent corticosteroid, substitution if needed by pharmacy)

Pediatrics (weighing <40 kg): *(may adjust with weight changes)*

☐Diphenhydramine 1mg/kg PO
☐Acetaminophen 15mg/kg PO
☐Methylprednisolone 1 mg/kg (OR _____mg) slow IV push (or an equivalent corticosteroid, substitution if needed by pharmacy)

☐Other: _____
☒RN to instruct patient to hydrate pre/post infusion and educate on taking OTC diphenhydramine and/or acetaminophen per manufacturer dosing recommendations as needed to prevent/treat post-infusion headache.
☒RN to monitor patient for at least 30 minutes post infusion and educateon possible side effects, allergic reaction, and when to contact provider

6. Adverse Reaction Orders

☒Standard anaphylaxis kit to be dispensed and dosed per protocol: Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL), and NS IV. Additional orders: _____

7. Prescriber Information

Prescriber Name: _____ Office Contact: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
License #: _____ DEA #: _____ NPI: _____

_____ _____ _____ _____
Physician Signature (Substitution Permitted) **Date** **Physician Signature (Dispense as Written)** **Date**