SPECIALTY INFUSION CENTER
An Access Infusion Care Company

INTRAVENOUS IMMUNOGLOBULIN ORDERS

CENTERS AT SIC
An Access Infusion Care Managed Company

REFERRAL CHECKLIST
Please ensure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ CBC w/diff/CMP/Quantitative immunoglobulins/lymphocyte subset panel (if applicable to dx)
☐ Completed and Signed Referral
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

©Specialty Infusion Center
Print, complete, and fax completed form to (855) 857-3834

SPECIALTY INFUSION CENTER
An Access Infusion Care Company

CENTERS AT SIC
An Access Infusion Care Managed Company

INTRAVENOUS IMMUNOGLOBULIN ORDERS

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Ht: Wt: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ New Referral ☐ Continuation Order ☐ Dose or Frequency Change

First dose? ☐ Yes ☐ No - Date of last infusion:	Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other:

DIAGNOSIS

☐ Dx Code/description:

REQUIRED DOCUMENTATION ☐ Signed order ☐ Demographics/insurance info ☐ H&P/labs/tests/progress notes supporting the Dx

Prior Therapies:

PRESCRIBING INFORMATION

LAB ORDERS

Frequency: Every Labs: ☐ CMP ☐ CBCwdif ☐ CRP ☐ Sed Rate ☐ Quantitative immunoglobulins ☐ Lymphocyte subset panel ☐ Other:

PREMEDICATIONS (administer 30 minutes prior to infusion)

Acetaminophen: ☐ 650mgPO ☐ 1000mgPO	Methylprednisolone: ☐ 100mgIV ☐ 125mgIV ☐ mgIV
Diphenhydramine: ☐ 25mgPO ☐ 50mgPO ☐ 25mgIV ☐ 50mgIV	Other: ☐

MEDICATION

Medication	Dose/Strength	Directions	Quantity
☐ **Gammagard Liquid 10%** ☐ **Gamunex-C 10%** ☐ **Privigen 10%** ☐ **Other:** ☐ **Octagam 10%** ☐ **No Product Preference**	☐ Gm ☐ mg/kg	☐ x day(s) every weeks ☐ divided over days every weeks ☐ Infuse IV as directed per the PI and as tolerated	☒ # vials sufficient for dose Refills:

HYDRATION

Pre-Infusion: Fluid- ☐ 0.9%NS ☐ Other: Volume- ☐ 250ml ☐ 500ml ☐ 1000ml

Post-Infusion: Fluid- ☐ 0.9%NS ☐ Other: Volume- ☐ 250ml ☐ 500ml ☐ 1000ml

If no product preference, pharmacist to select product based on payor requirements/availability/indication unless otherwise noted.
Use current documented weight;
Round calculated dose to nearest dose achievable using whole vials of one available vial size within ±10% of calculated dose.
If not specified, order will be valid for 1 year from the date of signature.

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:Use 50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain SpO_2 95-100%.

Prescriber Signature X: _____ **Date:** _____

☐ **Product Substitution Permitted** ☐ **Dispense as Written**

©Specialty Infusion Center
Print, complete, and fax completed form to (855) 857-3834