IVIG PRESCRIPTION FORM

Owl Rexall Drug
837 W. Arrow Hwy, Glendora, CA
Phone: 626-962-1061
Fax: 626-962-1157
www.OwlRexall.com

Patient Information: please provide a copy of the patient's insurance card or information					
Date:	**Patient name:**	**DOB:**	**Gender:** ☐ F ☐ M	**HT:**	**WT:**
Address:		**City:**	**State:**	**Zip Code:**	**Phone:**
Insurance:			**ID#:**		**Group #:**
Allergies: ☐ NKDA ☐ List allergies:					

Clinical Information: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization	
Diagnosis / ICD-10:	**IVIG indication required for administration:** ☐ Idiopathic Thrombocytopenic Purpura ☐ Primary Immunodeficiency Syndrome ☐ Chronic Inflammatory Demyelinating Polyneuropathy ☐ Other (specify):

Vital Signs: ☐ Monitor BP q15min for the first hr of initial infusion, then q30-60min for the remainder of IVIG infusion
☐ Monitor BP q30-60min for subsequent IVIG infusions

Notify Physician if any of the following are observed: ☐ SBP is less than 90 mmHg or greater than 180 mmHg
☐ DBP is less than 50 mmHg or greater than 90 mmHg ☐ Temperature is greater than 101.5 degrees F ☐ Heart Rate is less than 50 or greater than 120
☐ RR is less than 10 or greater than 30 respirations/min ☐ Urine Output is less than 30 mL/hr or 240 mL/shift
☐ Pulse Oximetry is less than 90% ☐ SBP is less than 90 mmHg or greater than 180 mmHg

Blood Test: CBC, Metabolic Panel (chem-7) daily, prior to each infusion, Immunofixation, Immunoglobulins quantitation (Before 1st/_____ treatment, fax results to pharmacy)

Treatment	
Decrease IVIG rate or stop infusion and notify physician if patient experiences adverse reactions: hypotension, chest tightness, fever, chills, or nausea/vomiting	**Pre-Medication:** ☐ Acetaminophen 650 mg po one time 30-60 min prior to each dose of IVIG ☐ Diphenhydramine 25 mg po one time prn 30-60 min prior to each dose of IVIG ☐ Other:
Immune Globulin: ☐ Predisposed to renal insufficiency, minimize rate of infusion ☐ Patient has not been treated previously with IVIG, initiate at a lower concentration or lower rate	

Pharmacist will round down to nearest vial and maintain at least 90% of calculated dose. If dose deviates by more than 10% of calculated dose, Pharmacist may round up to nearest vial.
☐Patient has been previously treated with IVIG and tolerated therapy ☐ Patient has NOT been previously treated with IVIG
☐ Pharmacist to use current weight for dose calculations ☐ Use (specify): _____ kg as dosing weight
☐ Immune globulin 0.4 g/kg IV daily Initiate first dose at 15 to 30 mL/hr and increase rate every 30-60 minutes for duration of the infusion. For subsequent doses, titrate every 15 to 30 minutes to a final maximum rate listed in infusion table.

RX: IVIG _____ Grams _____Days Infusion Rate:_____cc/hr for the 1st hr _____cc/hr for the second hr
_____cc/hr thereafter

Repeat/Maintenance treatment in: _____ or every _____/ month

Dose: _____ Frequency: _____ Start Date: _____ Duration: _____

Hypersensitivity Anaphylaxis Management		
Vital Signs: ☐ Vital signs every 2 minutes until stable. Then, every 5 minutes for 30 minutes, then every 15 minutes until hypersensitivity/anaphylaxis reaction subsides.	**Assessments: ☐ Stop the administration of any agent causing hypersensitivity/ anaphylaxis reaction immediately.** **☐ Remain with patient, maintain airway & perform CPR if necessary.**	☐ Sodium chloride 0.9% bolus and infusion ☐ Sodium chloride (NORMAL SALINE) 0.9 % bolus 1,000 mL 1,000 mL, IV, once, for 30 minutes
☐ Epinephrine 1:1000 (1mg/mL) injection 0.3 mg, Intramuscular, once PRN for hypersensitivity/anaphylaxis reaction. May repeat every 5-10 minutes x 3 doses. If not effective, then may give epinephrine 0.5 mg IM. Epinephrine should be administered first, as soon as the diagnosis of anaphylaxis is suspected.		☐ Epinephrine 1:1000 (1mg/mL) injection 0.5 mg, Intramuscular, once PRN for severe cases of hypersensitivity/anaphylaxis reaction. May repeat every 5-10 minutes Epinephrine should be administered first as soon as the diagnosis of anaphylaxis is suspected.
☐ Hydrocortisone injection 100 mg IV over 30-60 seconds once PRN for hypersensitivity/anaphylaxis reaction		☐ Diphenhydramine injection 50 mg IV push once PRN over 1-2 minutes for hypersensitivity/anaphylaxis reaction (25 mg/min maximum).
☐ Loratadine 10 mg PO once for hypersensitivity/anaphylaxis reaction		☐ Methylprednisolone injection 125 mg IV once for hypersensitivity/anaphylaxis reaction

Notes

Physician Information				
Physician name:		**Phone:**	**Office contact:**	
Physician address:	**City:**		**State:** CA	**Zip:**
NPI:	**DEA:**	**Fax and/or Email:**		
Signature:		**Date:**	**☐ DO NOT SUBSTITUTE**	