IVIG Intake Form (Immunodeficiency)

Demographic Information

Last Name:		First Name:		SS#:
Home Address:			City:	State: Zip:
DOB:	Height:	Weight:	Allergies:	
Phone (H):		Phone (C):		Phone (W):

Emergency Contact:_____ Patient Gender: ☐ Male ☐ Female

Phone (H):_____ Phone (C) _____ Phone (W)_____

Insurance Information

Primary Insurance:		Subscriber Name:
Policy #:	Group #:	PCN:
RX BIN:	Insurance Phone:	
Secondary Insurance:		Subscriber Name:
Policy #:	Group #:	PCN:
RX BIN:	Insurance Phone:	

Diagnosis

☐ 279.0 Deficiency of Humoral Immunity

☐ 279.06 Common Variable Immunodeficiency

☐ 279 Immune Mechanism Disorder

☐ 279.04 Agamma Globulinemia: X-Linked

☐ V42.81 BMT

☐ 279.3 Immunity Deficiency NOS

☐ 204.9 Chronic Lymphocytic Leukemia

☐ 042 Pediatric HIV

☐ V42.82 PBSCT

☐ 446.1 Kawasaki Syndrome

☐ 279.2 Severe Combined Immunodeficiency (SCID)

☐ Other: _____

☐ ICD9: _____

Additional Medical History

History of: ☐ Renal Insufficiency ☐ Diabetes ☐ HTN ☐ CHF ☐ Thromboembolic event

☐ Other:_____

Physician Information

MD:	License:	NPI:
Hospital/Clinic:		Phone:
Fax:	Address:	
Office Contact:	Medicaid #:	

Referral Phone: 787-704-2025
Referral Fax: 787-704-2027

Patient Name: _____ Date of Birth: _____

Prescription & Product Information

☐ *May Not Substitute*

IVIG Product:	Concentration %:

Dose: _____mg/kg (+/- 10%) = _____ grams

Frequency: Repeat dose ☐ Daily for _____ days every _____ weeks ☐ Weekly ☐ Monthly
Other: _____
x _____ doses # of Refills_____

Administration Rate: ☐ Per manufacturer guidelines, as tolerated ☐ Other _____

Patients at risk for renal involvement will be run at a conservative rate

Has the patient received IVIG previously? ☐ Yes ☐ No	Date of last dose:

Pre Medications

☐ Hydration: ☐ Prior to ☐ During ☐ Following infuse:_____ mL _____ solution

☐ Benadryl: ☐ 25mg ☐ 50mg 15-25 minutes prior to infusion ☐ PO ☐ IVP

☐ Tylenol: ☐ 650mg ☐ 1000mg 15-25 minutes prior to infusion PO

☐ Solu-Cortef 100mg/2mL ☐ Solu-Medrol 125mg/2mL _____mg slow IVP: ☐ **pre** ☐ **halfway** ☐ **upon completion**

☐ Lidocaine cream 4% applied topically for venous or port access

Other:

Delivery Method

☐ Gravity using rate control device ☐ Pump Vascular Device: ☐ PIV ☐ Central: _____

Flushes

Normal Saline: ☐ 5mL ☐ 10mL ☐ Pre/Post Infusion ☐ 20mL ☐ Post infusion

Heparin: _____mL (_____ u/mL) as SASH

Nursing Assessment

☐ -Skilled nursing visit to: establish IV access, medication administration as prescribed, provide patient education related to disease state/therapy, assess general status and response to therapy. Frequency determined by therapy schedule.

☐ -Obtain baseline vital signs

☐ -Monitor vital signs every 15 minutes for first hour. Every 30 minutes for second hour. Then hourly to completion.

☐ -Provide needles, syringes, VAD and other ancillary supplies required for safe infusion.

☐ -Discontinue use and notify prescribing physician if patient demonstrates any of the following:
Fluid overload, cardiovascular symptoms, allergic reaction, moderate/severe headache, s/sx Aseptic Meningitis.

☐ -RN to draw following labs: _____

Frequency _____

Procedure for Anaphylaxis (pharmacy to provide)

1. Stop Infusion
2. Call 911 and prescribing physician immediately
3. Administer the following: ☐ Diphenhydramine 25-50mg slow IVP Q 4 hours PRN, dispense (1) 50mg vial
   ☐ Diphenhydramine 25mg capsules, use as directed, dispense 4 capsules
   ☐ Epinephrine (1:1000) 0.4mg subcutaneously PRN for anaphylaxis, dispense 1
   ☐ Normal Saline 500ml, use as directed, dispense 1 bag

I authorize SPS Specialty Pharmacy Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician Signature: _____ Date:_____

Referral Phone: 787-704-2025
Referral Fax: 787-704-2027