

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: <input type="checkbox"/> Male <input type="checkbox"/> 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

<input type="checkbox"/> 279.0 Deficiency of Humoral Immunity	<input type="checkbox"/> 279.3 Immunity Deficiency NOS
<input type="checkbox"/> 279.06 Common Variable Immunodeficiency	<input type="checkbox"/> 204.9 Chronic Lymphocytic Leukemia
<input type="checkbox"/> 279 Immune Mechanism Disorder	<input type="checkbox"/> 042 Pediatric HIV
<input type="checkbox"/> 279.04 Agamma Globulinemia: X-Linked	<input type="checkbox"/> V42.82 PBST
<input type="checkbox"/> V42.81 BMT	<input type="checkbox"/> 446.1 Kawasaki Syndrome
<input type="checkbox"/> Other: _____	<input type="checkbox"/> 279.2 Severe Combined Immunodeficiency (SCID)
<input type="checkbox"/> 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: _____

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08/08/13

SPS SPECIALTY PHARMACY SERVICES