Premier SPECIALTY INFUSION

IMMUNE DEFICIENCY ORDER FORM

P: 800.783.9655
F: 877.770.4179

PATIENT INFORMATION

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Cell: _____
DOB: _____ SSN: _____
Gender: ☐ Male ☐ Female
Emergency Contact: _____
Phone: _____ Relationship: _____

Ht: _____ ☐ in ☐ cm Wt: _____ ☐ lb ☐ kg

PRIMARY DIAGNOSIS

ICD 10

- ☐ D83.9 Common Variable immunodeficiency
- ☐ D80.0 Congenital Hypogammaglobulinemia
- ☐ D80.5 Immunodeficiency with Increased IgM
- ☐ D81.9 Combined Immunodeficiency, unspecified
- ☐ D81.89 Other Combined Immunodeficiencies Wiskott-Aldrich Syndrome
- ☐ D82.0
- ☐ D69.3 Immune Thrombocytopenic Purpura
- ☐ Other: _____

Please attach:

- ☐ Patient demographics, including insurance information
- ☐ Labs - Antibody testing results, most recent BUN/SCr and IgA level
- ☐ H&P
- ☐ For immune deficiency: Detailed infection history, baseline IgG levels (including subclasses), immune response to vaccinations (including report)
- ☐ Other: _____

IVIG Dose Needed Before SubQ Ig?

- ☐ No
- ☐ Yes - approximately 1 week before SubQ as below:

Immune Globulin Prescription:

IVIG _____ **gm** or _____ **gm/kg** x 1 dose

OK to round to the nearest 5 gm vial size

SCIG Dose: Pharmacist to determine dose ☐

Recommended Orders for IV Dose:

- Acetaminophen* 325mg: 2 tabs po pre-IG PRN ☐ Decline
- Diphenhydramine* 25mg: 1 cap po pre-IG PRN ☐ Decline
- If peripheral line**: NS 10ml syringe: Flush with 2 - 3ml pre/post use & Heparin 10 units/ml 5ml syringe: Flush with 1 - 3ml post use as appropriate.

* Liquid dosage form in appropriate concentration/amount may be dispensed upon patient request

** For other line types, different flush orders needed.

- ☐ **Hizentra 20% (200mg/mL):**
  Total weekly Dose= _____grams
  Dispense: 4 week supply
- ☐ **Gamunex-C 10% (100mg/mL):**
  Total weekly Dose= _____grams
  Dispense: 4 week supply
- ☐ **Gammagard Liquid 10% (100mg/mL):**
  Total weekly Dose= _____grams
  Dispense: 4 week supply
- ☐ **Gammaked Liquid 10% (100mg/mL):**
  Total weekly Dose= _____grams
  Dispense: 4 week supply
- ☐ **Refill** _____ months(12-month maximum)

(unless noted, all prescriptions will be refilled 1 year from date signed)

Other Orders:

	Decline
Pharmacist to determine least number of sites for product administration based on manufacturer recommendations/restrictions	☐
0.9% Sodium Chloride flush to verify correct SC needle placement	☐
Anaphylaxis kit orders per PCA Anaphylactic Protocol	☐
Acetaminophen 650 mg *Sig:* Take by mouth every 4-6 hours PRN fever and/or headache	☐
Diphenhydramine 25 mg *Sig:* Take by mouth every 4-6 hours PRN itching	☐

PHYSICIAN INFORMATION

Physician's Name: _____

_____

Address: _____

City: _____ State: _____ Zip: _____

Phone# _____ Fax# _____

NPI: _____ Contact: _____

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Physician Signature: _____

Physician Email: _____

Date: _____