

Immune Globulin (Adult) Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.
Fax completed form, insurance information and clinical documentation to 414-260-7368.

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Height: _____ inches cm Weight: _____ lbs kg

Clinical Information

Primary Diagnosis Description: _____ ICD-10 Code(s): _____

Immune Globulin Prescription

Immune globulin refill as directed x 1 year Requested brand _____

Loading Dose: _____

Maintenance Dose: IV Subcutaneous

Infuse _____ gm for _____ day(s) every _____ week(s)

Infuse _____ gm/kg (ideal body weight) divided over _____ day(s) every _____ week(s)

Other: _____

Pharmacist to identify clinically appropriate IG brand and infusion rates. May substitute product based on product availability. Infuse entire contents of IG infusion bag/vial(s) per current dose. May infuse +/- 4 days to allow for patient scheduling. Round dose to nearest whole 5 gm vial for IV doses and nearest single-use vial size for subcutaneous doses.

Ancillary Orders

Anaphylaxis Orders

Treat per Froedtert Home and Specialty Infusion protocol.

Pre-Medication Orders

Acetaminophen _____ mg PO 30 min before infusion. Patient may use own supply or patient may decline.

Diphenhydramine _____ mg PO 30 min before infusion. Patient may use own supply or patient may decline.

Other: _____

Other: _____

Labs and frequency: _____

IV Access and Flush Orders: RN to access and monitor venous infusion line as indicated below:

Peripheral: Flush with 0.9% NS - 10 ml pre/post-use.

Implanted Port or PICC: Flush with 0.9% NS - 10 ml pre/20 ml post-use and 10 ml pre/20 ml post-lab draw.

Skilled nurse to administer doses intravenously where applicable. Nurse will provide ongoing support, including administration of medication, PRN. Refill above ancillary orders as directed x 1 year.

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

Prescriber Signature _____ Date _____ Time _____

Prescriber Name _____ Phone _____ Fax _____

Address _____ NPI _____

City, State, Zip _____ Office Contact _____



Original - Medical Records

Froedtert Home and Specialty Infusion
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