

# Immune Globulin (Pediatrics) 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 the nearest single-use vial size.

## 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: \_\_\_\_\_

**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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