Froedtert Health Home Infusion

Subcutaneous Immune Globulin (SCIG) Order Form

Phone: 262-532-5124 (Intake) | Fax: 262-532-5114

Froedtert Pharmacy

Patient Information		Physician Information	
Patient Name:	Date of Birth:	Name:	
MRN #: I certify the following information is up to date in patient's chart: demographics, medication list, allergies		DEA #:	NPI:
		Telephone:	

Clinical Information

ICD-10 immunology: ☐ D80.0 Congenital Hypogam ☐ D83.9 CVID (unspecified) ☐ D81.9 SCID (unspecified)

ICD-10 neurology: ☐ G61.81 CIDP ☐ G61.82 MMN ☐ G35 MS (rel remit) ☐ G61.0 GBS ☐ G70.01 MG

ICD-10 rheumatology: ☐ M33.20 Polymyositis ☐ M33.90 Dermatomyositis

Other: ____

Other drugs used to treat the disease: ___________________________________

Has the Patient Received IVIG Previously? ☐ Yes ☐ No Product: ______________

Ht: _______ cm/in Wt: ________ kg/lbs Date: _________

☐ Attach patient demographics, insurance information, and medication list.

☐ Attach Clinical Documentation

Primary Immune Deficiency– H&P, documented infection history/treatment, Pre-treatment and current IgG, IgA, IgM, and Ig subclass serum levels.

Neuromuscular Disorders – H&P (diagnosis of disorder must be unequivocal), documentation that other causes of demyelinating neuropathy have been excluded. For Myasthenia Gravis – tensilon test results and 6 month trial of corticosteroids.

Rheumatology - H&P, creatine phosphokinase values, electromyography and/or muscle biopsy results

Immune Globulin Prescription

Preferred Product: ______________ - Infuse ______ **grams** *or* ______ **grams per kg** subcutaneously every ______ week(s) or days

Infuse total dose of immune globulin subcutaneously in 1 to multiple sites via infusion pump as tolerated. Infusion rates per manufacturer recommendation, as tolerated.

Quantity/Refills: Dispense 1 month supply. Refill x 1 year unless noted otherwise.

Dispense: Sizes & quantities sufficient Round to nearest vial size as clinically appropriate

Other Instructions: ____

Premedication to be given 30 minute prior to infusion:

☐ Diphenhydramine 25mg by mouth (contraindicated in myasthenia gravis) ☐ Acetaminophen 650mg by mouth

☐ Other: ____

Medications to be used as needed: *(please strike through if not required)*

- Diphenhydramine 25mg by mouth every 4–6 hours as needed for mild infusion reactions, may increase to 50mg for moderate to severe; maximum of 4 doses per day (contraindicated in patients with myasthenia gravis)
- Acetaminophen 650mg by mouth every 4–6 hours as needed for fever, headache or chills; maximum of 4 doses per day

Adverse reaction medications: *(keep on hand at all times)*

- Epinephrine 0.3mg auto-injector 2-pk for patients weighing greater than or equal to 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose

Supplies: (*please strike through if not required)*

- Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

Nursing Services: *(please strike through if not required)*

- Skilled nursing visits to educate patient on subcutaneous access, medication administration, use of supplies, therapy and disease state and to assess general status and response to therapy; patient discharged from nursing once teaching complete.

Other Orders (i.e. Labs):

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

Prescribers Signature: ____ **Date:** _________________

Office Contact: Phone:

***Note**: The medical information in this attachment has been released according to Wisconsin State Statutes 146.81-.83, 250, 252, 51.30 and Federal Law 42 CFR and 45 CFR. Confidentiality of this information is protected. The recipient of this information is prohibited from redisclosing the information to any other party under these statutes.*

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