



# HOME PARENTERAL SERVICES

## Intravenous Immune Globulin

PHONE: 1-800-637-9201  
FAX: 1-417-269-0692

### Patient information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Sex:  Female  Male SS #: \_\_\_\_\_  
1° Language: \_\_\_\_\_ Wt: \_\_\_\_\_  kg  lbs Ht: \_\_\_\_\_  cm  in  
Address: \_\_\_\_\_  
Apt/Suite: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_  
Caregiver name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Local Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

### Prescriber + Shipping Information

Prescriber Name: \_\_\_\_\_  
NPI #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Apt/Suite: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Contact: \_\_\_\_\_  
Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_  
Fax: \_\_\_\_\_  
Email address: \_\_\_\_\_  
If shipping to prescriber:  1st Fill  Always  Never

### Insurance Information (Please fax a copy of front and back of the insurance cards)

1° Insurance Plan: \_\_\_\_\_ Plan ID #: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Relation: \_\_\_\_\_  
2° Insurance Plan: \_\_\_\_\_ Plan ID #: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Relation: \_\_\_\_\_

### Clinical Information (Please fax all pertinent clinical and lab information)

ICD-10/Diagnosis Code: \_\_\_\_\_  
Date of Diagnosis: \_\_\_\_\_ Access:  Peripheral Butterfly  PICC  Implant Port  Broviac®/Hickman®  
IgA deficiency:  Yes  No IgA level \_\_\_\_\_ mg/dL Date: \_\_\_\_\_ Has patient received immune globulin previously?  Yes  No  
IgG trough: \_\_\_\_\_ mg/dL Date: \_\_\_\_\_ Diabetic:  Yes  No If yes, product information: \_\_\_\_\_  
Comorbidities: \_\_\_\_\_ Date of last infusion: \_\_\_\_\_ Date of next infusion: \_\_\_\_\_  
Allergies:  NKDA  Other: \_\_\_\_\_

### Prescription

Per HPS protocol

- PIV: 0.9% Sodium Chloride 3-20 ml before and after infusion as needed
- Port : Bacteriostatic 0.9% Sodium Chloride 3-20ml into port at time of access or at least monthly, 0.9% Sodium Chloride 3-20 ml before and after infusion and as needed,
- Heparin 100units/ml 5ml as lock after infusion if de-accessing
- Heparin 10 units/ml 5 ml flush after infusion if remaining accessed/ maintaining line

#### Pre-Medication Orders:

- Diphenhydramine \_\_\_\_\_ mg PO 30 minutes prior to infusion
- Diphenhydramine \_\_\_\_\_ mg IV in 10ml NS 15-30 minutes prior to infusion
- Acetaminophen 650mg PO 30 minutes prior to infusion
- Hydration: Infuse \_\_\_\_\_ ml \_\_\_\_\_ solution IV over \_\_\_\_\_ minutes  
 Prior to infusion OR  During infusion
- Hydrocortisone \_\_\_\_\_ mg IV in 10 ml NS 15-30 minutes prior to infusion
- Methylpredisolone \_\_\_\_\_ mg IV in 10 ml NS 15-30 minutes prior to infusion
- Other: \_\_\_\_\_

#### Immune Globulin Products:

Pharmacy to determine or  Other: \_\_\_\_\_

#### Therapy Regimen:

Dose : \_\_\_\_\_ g/kg Current weight: \_\_\_\_\_  
Pharmacist will continue subsequent dosing based off of initial weight and will round dose up to the nearest vial size.

Frequency: Daily for \_\_\_\_\_ days per week every \_\_\_\_\_ weeks  Other: \_\_\_\_\_

Rate: Administer per HPS protocol or  Other: \_\_\_\_\_

Duration: Refills x 1 year or \_\_\_\_\_ infusions

#### Note:

Orders are initiated unless crossed out by provider

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Substitution Permitted Dispense as Written

I authorize Home Parenteral Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Home Parenteral Services.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 1-800-637-9201.