CoxHealth at Home

Intravenous Immune Globulin

PHONE: **1-855-419-4663**
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 presciber: ❑ 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: _____
IgA deficiency: ❑ Yes ❑ No IgA level _____ mg/dL Date:_____
IgG trough:_____mg/dL Date:_____ Diabetic: ❑ Yes ❑ No
Access: ❑ Peripheral Butterfly ❑ PICC ❑ Implant Port ❑ Broviac®/Hickman®
Has patient received immune globulin previously? ❑ Yes ❑ No
If yes, product information: _____
Date of last infusion: _____ Date of next infusion: _____
Comorbidities: _____
Allergies: ❑ NKDA ❑ Other: _____

Prescription

Per CoxHealth at Home 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 inital weight and will round dose up to the nearest vial size.

Frequency: Daily for ____ days per week every _____weeks ❑ Other:_____

Rate: Administer per CoxHealth at Home protocol or ❑ Other:_____

Duration: Refills x 1 year or _____infusions

Note:
Orders are initiated unless crossed out by provider

Prescriber's Signature:_____ Date: _____

I authorize CoxHealth at Home 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 CoxHealth at Home.

CoxHealth