Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____/_____/_____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

Office Fax # (_____) _____-_____

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

IVIG Treatment Plan

Patient Name: _____ **Patient DOB** _____/_____/_____

General

☐ Diagnosis- _____ ICD-10 Code _____

Pt. Weight _____ Pt Height _____ Known Allergies _____

Requested Start Date ____/____/_____

Has patient previously received this medication ☐ No ☐ Yes, if so, date of last infusion ____/____/_____

Authorized Treatment Duration ☐ Infuse Once ☐ Orders valid for 1 year

Infusion (Month 1 to 12) Duration: 12 Months

☑ Vital Signs (Month 1 to 12) BP/HR/Resp/SpO2/Temp
Baseline on arrival to unit, prior to every rate increase, hourly after reaching max rate, and prior to discharge.

***Note: Pharmacy will interchange biosimilar product per insurance approval. If interchange is NOT allowed by provider, please indicate preferred product here: Preferred Product: _____

Pre- Treatment Medications

Acetaminophen (Month 1 to 12)

☐ *650 mg, Oral, Tab, Day of Tx*
Comments: Administer 30 minutes before dose

Diphenhydramine (Month 1 to 12)

☐ *25 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before dose

☐ *50 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before dose

Methylprednisolone (Month 1 to 12)

☐ *40 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before dose

☐ *125 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before dose

Provider Acknowledgement

* IVIG may interfere with the response to any live vaccines. Such vaccines should be avoided within 6 months of IVIG administration: Measles, and Varicella immunizations should be deferred for greater than or equal to 11 months after receiving IVIG. IVIG should be administered at the minimum dose and rate possible in patients at risk of renal dysfunction. Referring providers agrees to monitor renal function and notify Conway Infusion Services if renal function deteriorates resulting in therapy discontinuation. IVIG has been associated with risks of thrombotic events and should be administered at the minimum dose and infusion rate possible.

Provider Initials_____

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____

IVIG Treatment Plan

IVIG

Dose (Pick one)

☐ _____ gm/kg (weight based)

☐ _____ gm (fixed dose)

Administration (Pick one)

☐ Dose above divided over _____days

☐ Dose above given daily for _____days

Frequency (Pick one)

☐ Single infusion

☐ Treatment course repeated every _____ weeks

Comments: Infusion rate to be determined by pharmacy based on IVIG product selected
Please see UpToDate Lexidrug Immune Globulin for rate reference based off product and diagnosis

☑ Communication Order
Constant order, If patient develops fever, chills, rigors, hypotension or respiratory difficulty during IVIG infusion, STOP infusion and call MD/LIP.

☑ Communication Order
Verify if patient has received any live vaccines in the last 6 months Measles and Varicella immunizations should be deferred for greater than or equal to 11 months after receiving IVIG.

☑ Notify Provider (Month 1 to 12)
Notify provider for temperature > 99.5 or HR < 55 or > 140, drop or rise in SBP more than 20 mm Hg from baseline

☑ Notify Provider (Month 1 to 12)
Notify provider for any live vaccine administration within the last 6 months and hold IVIG until provider clearance is received.

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

☐ **Labs:** _____

Dosing Calculation Disclaimer: Per CMC P&T approval, IVIG shall be dosed based on the following criteria. Doses will be rounded to the nearest manufacturer vial size by pharmacy:

- Pregnant patients: Dose using actual body weight.
- Non-pregnant patients:
  - Use actual body weight if actual body weight (ABW) is less than 120% of ideal body weight (IBW).
  - Use ADJUSTED body weight if actual body weight (ABW) is greater than 120% of ideal body weight (IBW).
- Males: IBW = 50 kg + 2.3 kg for each inch over 5 ft
- Females: IBW = 45.5 kg +2.3 kg for each inch over 5 ft
- ADJUSTED body weight = IBW + 0.4(ABW – IBW)

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB____/_____/_____