



toll free fax

Immune Globulin Transplant

Torrance, CA toll free

krogerspecialtyinfusion.com

Need By Date:

Patient Information

Patient Name		Parent/Guardian Name (if applicable)		<input type="checkbox"/> All Insurance Info Attached
Address		City State Zip		
Main Phone	Alternate Phone	Email		
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Weight (required) <input type="checkbox"/> kg <input type="checkbox"/> lbs	Height (required) <input type="checkbox"/> ft <input type="checkbox"/> in	
Other Drugs Used to Treat Patient's Condition		First Dose of IVIg: <input type="checkbox"/> No <input type="checkbox"/> Yes		Prior Ig Products Tried
Adverse Reactions with Previous Ig Treatments		Allergies <input type="checkbox"/> NKDA		

Primary Diagnosis

294.0 Kidney Transplant 294.1 Heart Transplant 294.2 Lung Transplant
 Other: _____ ICD-10: _____

Please include the following information:

- Demographics H&P Physician Orders Insurance Information Labs

Prescription and Orders

Infuse IVIG: _____ grams or _____ gm/kg IV over _____ hours as tolerated

Frequency: _____

Duration: _____

Pharmacy to Select IVIG Product

Infusion Rate: (please select one and provide complete information)

Pharmacist to determine

Start at _____ mL/hr, then increase by _____ mL/hr every _____ minutes to maximum rate _____ mL/hr

Access: Peripheral PICC Port Other: _____

IV Maintenance (Flushing): Dispense Quantity Sufficient

- Sodium Chloride 0.9% 10mL Prefilled Syringe: Flush IV access device with sodium chloride 3-10mL to maintain line patency.
- Heparin 10 units/mL 5mL Prefilled Syringe: Flush peripheral IV access device with Heparin 10 units/mL 1-5 mL as needed to maintain line patency.
- Heparin 100 units/mL 5mL Prefilled Syringe: Flush central IV access device with Heparin 100 units/mL 3-5 mL as needed to maintain line patency.

Adverse/Anaphylactic Reactions: Anaphylaxis kit to be used in the event of anaphylactic reaction and will contain the following:

- Diphenhydramine 25mg Capsule #2
- Diphenhydramine 50mg/mL 1mL Vial #1
- Epinephrine Injection Auto-Injector 0.3mg (>30kg pt) or 0.15mg (<30kg pt) Two-Pack #1
- Sodium Chloride 0.9% 500mL Bag #1
- Sodium Chloride 0.9% 10mL Prefilled Syringe #4

Pre-Treatment: Dispense Quantity Sufficient

Acetaminophen 325mg Tablet: 1-2 tablets by mouth 15-30 minutes before each infusion. Decline

Diphenhydramine 25mg Capsule: 1-2 capsules by mouth 15-30 minutes before each infusion. Decline

Other: _____

Ancillary Supplies: Dispense ancillary supplies and equipment needed to provide home infusion therapy.

Labs: Results will be faxed to physician's office. If no frequency noted, ordered labs to be done prior to initial infusion only. Labs will not be drawn on weekends/holidays. Not appropriate for STAT labs.

Labs to be Drawn: _____ Frequency of Labs: _____

Nursing Orders for Home Infusion MONITOR (IV Only)

- **Observe:** Vital signs prior to infusion. Blood pressure and pulse every 15 minutes for first hour, then every 30 minutes until stable infusion rate, then every hour.
- **Watch for:** Signs of fluid overload, cardiovascular symptoms, allergic reactions, skin rash, fever, and moderate to severe headache.
- **Call/Page MD:** For adverse events, stop the infusion. Can restart the infusion at the same or lower rate pending physician's approval or if symptoms subside.

Physician Information

Physician Name		DEA #	NPI #	License #
Address		City State Zip		
Phone	Fax	Office Contact (required)		

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Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date