Hy-Vee health™

# IMMUNOGLOBULIN (IG)
## IV and Sub-Q Orders

**PHONE** 515.225.2930 | **FAX** 515.559.2495

## Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

**Patient Name:** ____________ **DOB:** ____________ **Phone:** ____________

**Patient Status:** New to Therapy Continuing Therapy **Date of last infusion:** ____________

## Medical Information

**ICD-10 Code** (required): ____________ **ICD-10 description:** ____________

Patient Weight: ______ kg Height: ______ Diabetic: Yes No If obese, use adjusted body wt? Yes No

Allergies: ____________ Brand previously used: ____________

## Therapy Order

IV Sub-Q **Pharmacist to identify clinically appropriate brand/infusion rates. May substitute based on product availability.**

| | | | | |
|---|---|---|---|---|
| **Loading dose** ***(as applicable)*** | ______ | mg/kg<br>gm/kg<br>grams | x ______ day(s) **OR** divided over ______ days | One time dose<br>Other: ______<br>**Give maintenance dose ______ weeks after loading dose** |
| **Maintenance dose** | ______ | mg/kg<br>gm/kg<br>grams | x ______ day(s) **OR** divided over ______ days | Q ______ weeks x1 year<br>Other: ______ |

Do not substitute. Administer brand: ____________

- Infuse entire contents of Ig infusion bag/vial(s) per current dose.
- If needed, round dose to nearest whole 5 gm vial for IV doses and nearest single-use vial size for Sub-Q doses.

**Premedication orders:** *to be administered 15-30 minutes before infusion.*

Acetaminophen 500 mg PO
Solu-Medrol ______ mg IVP
Loratadine 10 mg PO
Normal Saline 500 mL IV
Diphenhydramine 25 mg PO
Diphenhydramine 25 mg IV
Cetirizine 10 mg PO
Quzyttir 10 mg IVP
Other: ____________

**Lab orders:** ____________ **Lab frequency:** Each infusion Other: ____________

Required labs to be drawn by Hy-Vee Health Referring Provider

**Anaphylactic reaction orders:**

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen® 0.3 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen® 0.15 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
- Diphenhydramine – Administer 25-50 mg orally OR IV (adult), refer to provider orders or policy for pediatric dose
- NS 500 mL IV bolus as needed for IVIg therapy (adult), refer to provider orders or policy for pediatric bolus

**Flush orders:** NS 1-20 mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

## *For Hy-Vee Health Use Only

**Drug/Brand Selection:** ____________ **Date:** ____________

**NP/Pharmacist Name:** ____________ **NP/Pharmacist Signature:** ____________

## Physician Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

**Provider Name:** ____________ **Signature:** ____________ **Date:** ____________

**Provider NPI:** ____________ **Phone:** ____________ **Fax:** ____________ **Contact Person:** ____________

Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): ____________

## Service Areas

Des Moines, IA West Des Moines, IA Chicago, IL Omaha, NE Buffalo, NY Dallas, TX Phoenix, AZ Other ______

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# COMPREHENSIVE SUPPORT FOR IMMUNOGLOBULIN THERAPIES

## **Required Documentation for Insurance Approval** General Requirements

- Patient demographics
- Insurance information
- All applicable diagnoses
- History and physicial
- Recent progress notes within 12 months
- Patient's height and weight
- Drug allergies
- Physician Orders
- Plus one of the following

## Common Variable Immunodeficiency (CVID)/Hypogammaglobulinemia/Parkinson's Disease (PD)

- Lab last showing Ig levels and subclasses Ig levels.
- Documentation of recurrent infections
- History of antibiotic usage – showing failure to respond to antibiotics
- Documented inadequate response to pneumococcal vaccine or tetanus/diphtheria

## Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)/Guillain-Barré Syndrome (GBS)

- Labs
- Nerve conduction study, electromyography (EMG)
- Nerve and/or muscle biopsy (if available)
- Nerve conduction velocity (NCV) test results
- Tried and failed treatments
- Spinal tap (if available)

## Myasthenia Gravis

- Exacerbation
- Any history of crisis
- Thymectomy
- Any symptoms that affect respiration, speech or motor function
- Tried and failed treatments

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