

IMMUNOGLOBULIN (IG) NEUROLOGY RX ENROLLMENT FORM

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Gender: _____
 Home Phone: _____ Cell Phone: _____ Email: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Emergency Contact: _____ Emergency Phone: _____

CLINICAL INFORMATION

Patient Weight: _____ kg lbs
 Patient Height: _____ cm in
 Allergies: _____
 Has patient previously received IG? Yes No
 Pharmacy to coordinate home health nursing visit and/or nursing training
 Patient already trained on subcutaneous infusion

PRESCRIBER INFORMATION

Prescriber Name: _____
 DEA #: _____ NPI #: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 Contact Person: _____

PRESCRIPTION INFORMATION Pharmacy to select IG if medication left blank

MEDICATION Pharmacy to select IG Brand _____

DIAGNOSIS

- G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- G61.82 Multifocal Motor Neuropathy (MMN)
- G70.01 Myasthenia Gravis with Acute Exacerbation
- G61.0 Guillain-Barré Syndrome
- M33.10 Dermatomyositis
- G70.80 Lambert-Eaton Syndrome
- G13.0 Paraneoplastic neuromyopathy and neuropathy
- M33.22 Polymyositis with myopathy
- G25.82 Stiff-man Syndrome
- G35 Multiple Sclerosis (Relapsing/Remitting)
- Other _____

Infusion Route Intravenous Subcutaneous

Dose and Directions

Pharmacy to calculate based on the following weight: _____ kg lbs
 Loading Dose: Infuse _____ GRAMS daily for _____ day(s)
 -OR- Infuse _____ GRAM/KG divided over _____ day(s)
 Maintenance Dose: Infuse _____ GRAMS daily for _____ days, every _____ week(s)
 -OR- Infuse _____ GRAM/KG divided over _____ day(s), every _____ week(s)
 Other _____
 +/- 4 days to allow scheduling flexibility OK to round to the nearest vial size
 Multiple doses will be administered on consecutive days unless ordered otherwise.
 Rate protocol: Titrate initial and maintenance infusions per manufacturer's product labeling.

REQUIRED FOR HOME INFUSION RX to include diluents, needles, syringes, ancillary supplies, home medical equipment to administer infusion.

IV Access **To be administered PERIPHERALLY, unless otherwise indicated.** PORT PICC

Flush Protocol for IVIG drug admin days only
 • 0.9% NaCl: 1-10mL IV before/after infusion, or PRN for line patency/SASH.
 • Heparin 10 units/mL: 5mL IV (peripheral) PRN for final flush. *For multi-day infusions
 • Heparin 100 units/mL: 5mL IV (central) PRN for final flush.
 * For multi-day infusions, peripheral IV to be obtained, maintained, and discontinued for the duration of the infusion cycle per RN discretion in accordance with INS guidelines.

Pre and Post Medications Please strikethrough if not required	To be given by mouth 30 minutes prior to infusion. May repeat every 4-6 hours as needed.					*For subcutaneous patients only* if requested by patient/nurse. Lidocaine 2.5%/Prilocaine 2.5% topical (may dispense Lidocaine 4%) to injection site(s) at least 1 hour prior to needle insertion.
		Adult	6-12 years old	2-5 years old	<2 years old	
	Diphenhydramine	25mg-50mg max 100mg/day	12.5mg - 25mg	6.25mg - 12.5mg	1mg/kg up to max 6.25mg	
	Acetaminophen	325mg-650mg max 3000mg/day	10-15mg/kg			

Anaphylaxis Protocol
To be given intramuscularly PRN severe allergic reaction. Call 911. May repeat x 1.
 • Epinephrine 0.3mg (≥30kg/66lbs)
 • Epinephrine 0.15mg (15kg to <30kg /33lbs to <66lbs)
 • For IVIG only: Epinephrine ampule 0.1mg (7.5kg to <15kg /16.5lbs to <33lbs)

Hydration
 Please select only if needed for IVIG
 0.9% NaCl _____ mL infused over _____ minutes
 D5W _____ mL infused over _____ minutes
 Nurse to determine hydration rate if rate not provided above.
To be infused pre-infusion, unless otherwise indicated.
 Concurrent with Infusion Other _____

Diphenhydramine
 Please select only if needed
To be given via slow IV push PRN for moderate – severe reaction.
 25-50mg *For IV Adult Patients only* 1mg/kg/dose (Max dose 50mg) *For IV Pediatric Patients Only*

Quantity and Refills
 Dispense 1-month supply with 1-year refill unless indicated below.
 Dispense 3-month supply with 1-year refill Other _____

Additional Orders

PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

<input type="checkbox"/> May Substitute/Product Selection Permitted/Substitution Permissible	<input type="checkbox"/> Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute
Prescriber Signature _____	Prescriber Signature _____
Date _____	Date _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" NY & Iowa providers, please submit electronic prescription.