

**c:**

**e:**

**PATIENT INFORMATION**

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Last 4 SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

---

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

---

Primary Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

---

Gender: M F Weight lbs/kg: \_\_\_\_\_ Allergies: \_\_\_\_\_

---

**Patient Status:**  New to Therapy  Continuing Therapy

Date of last infusion (if applicable) \_\_\_\_\_  Next Due Date (if applicable): \_\_\_\_\_

---

**Primary Insurance:** \_\_\_\_\_ **Secondary Insurance:** \_\_\_\_\_

---

**Member#:** \_\_\_\_\_ **Group#:** \_\_\_\_\_ **Member#:** \_\_\_\_\_ **Group#:** \_\_\_\_\_

**Diagnosis**

- |  |  |
|--|--|
| Acute Infective Polyneuritis (Gullain-Barre Syndrome)    | Myasthenia Gravis with Acute Exacerbation    |
| Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) | Myasthenia Gravis without Acute Exacerbation |
| Critical Illness Polyneuropathy (Acute Motor Neuropathy) | Peripheral Neuropathy (Unspecified)          |
| Dermatomyositis  | Stiff-Person Syndrome                        |
| Multifocal Motor Neuropathy (MMN)                        | Other: _____                                 |
| Multiple Sclerosis (MS)                                  |  |

**Orders - Immune globulin**  *Pharmacy may round to nearest 5 gm vial size*

Preferred Product \_\_\_\_\_ No product preference

**Administer:** IV Sub-Q

**Initial:** \_\_\_\_\_ gm/kg divided over \_\_\_\_\_ days

**Maintenance:** \_\_\_\_\_ gm/kg every \_\_\_\_\_ weeks x 12 months  
 \_\_\_\_\_ grams every \_\_\_\_\_ weeks x 12 months  
 \_\_\_\_\_ gm/kg \_\_\_\_\_ x 12 months  
 \_\_\_\_\_ grams \_\_\_\_\_ x 12 months

Infuse dose over \_\_\_\_\_ hours or per manufacturer guidelines

**PRE-MEDICATION ORDERS**

- acetaminophen (Tylenol) PO  325mg /  500mg /  650mg
- diphenhydramine (Benadryl) PO  25mg /  50 mg
- hydration \_\_\_\_\_ Vol \_\_\_\_\_ ml pre &/or post infusion
- other: \_\_\_\_\_

**Flushes / Other**

- Normal Saline 10-20 ml before and after infusion and as needed
- Heparin \_\_\_\_\_ units/ml 3-5 ml after final saline flush if needed
- Supplies/pump as needed for IV/SC access and Ig administration

**NURSING**

- Establish and/or maintain access device as needed for dose administration
- Administer IVIg or teach SClg administration
- Obtain vital signs prior to, throughout as directed and at completion of infusion
- If reaction occurs follow procedure for reaction management

**Reaction Management**

- Diphenhydramine 25-50 mg IV PRN; Disp 1 vial
- NaCl 0.9% 500 ml IV PRN; Disp 1
- Epinephrine pen 1mg/ml; 0.3 ml in thigh as directed; Disp 1

*Mild or moderate reaction (non-life threatening); slow infusion and notify MD – i.e., flushing, fever, nausea/vomiting, hypotension, chills, dizziness, headache, body aches, chest tightness, SOB etc.*

*Severe reaction (life-threatening); Stop infusion immediately, call 911 as appropriate and notify MD – i.e., symptoms of anaphylaxis, thrombotic events or aseptic meningitis*

**PROVIDER INFORMATION**

*By signing I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. Axiva Health Solutions, Inc., has my permission to contact the patient's health plan to obtain authorizations necessary to enable it to receive payment for services.*

Physician Name: \_\_\_\_\_ NPI: \_\_\_\_\_ DEA: \_\_\_\_\_ License: \_\_\_\_\_

---

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

---

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Office Contact: \_\_\_\_\_

\_\_\_\_\_  
 Physician Signature Required – Substitution Permitted Date

\_\_\_\_\_  
 Physician Signature Required – Dispense as Written Date