Infusion Specialist:

c:

e:

Immunoglobulin (IVIg) for Infertility

Patient Referral Form

PATIENT INFORMATION

Date: Patient Name: Last 4 SSN DOB:

Address: City: ST: Zip:

Primary Phone: Work Phone:

Gender: ☐M ☐F Weight lbs/kg: Allergies:

Diagnosis

☐ Immunodeficiency Unspecified ☐ Other: _____

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

☐Preferred Product_____ ☐No product preference

Administer: IV

Initial: _____gm over one day every _____ weeks

☑ 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 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, thrombolic 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

FAX completed form to Axiva 844.440.0101 **Patient Navigator 844.44-AXIVA (844.442.9482)**