axiva

Immunoglobulin (IVIg)
Patient Referral Form

Infusion Specialist:

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

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 divided over _____days every _____ weeks x 12 months

_____ grams divided over _____days every _____ weeks x 12 months

Other: ____

☑ 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 SCIg 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)**