



PATIENT INFORMATION

Date: _____ Patient Name: _____ Last 4 SSN: _____ DOB: _____
Address: _____ City: _____ ST: _____ Zip: _____
Primary Phone: _____ Work Phone: _____ Email: _____
Gender: M F Height _____ Weight lbs/kg: _____ Allergies: _____

Diagnosis(ICD-10): _____

Documentation needed:

Date of Last Infusion (if applicable): _____ Next Infusion Due (if applicable): _____

- Most recent clinical including H&P
- Insurance cards
- Diagnostic testing results
- Demographics
- Labs/e.g (HLA,EBV,CBC,BMP)

ORDERS-Immunoglobulin 10% non Sucrose based _____ 5% non Sucrose based _____

Other Medications _____

Administer IV Load: _____ gm/kg divided over _____ days

Maintenance:

_____ gm/kg over _____ days every _____
_____ grams over _____ days every _____
Infuse dose over _____ hours or per manufacturer guidelines

Administer: Sub-Q _____ gm weekly
_____ grams over _____ days every _____ weeks

Infuse dose over _____ hours or per manufacturer guidelines
Other medication _____

PRE-MEDICATION ORDERS

- Acetaminophen (Tylenol) PO 325mg / 500mg / 650mg
- Diphenhydramine (Benadryl) PO 25mg / 50 mg
- Hydration (Sodium Chloride 0.9%)
Vol _____ ml pre&/ or post

Other _____

Flushes / Other Normal Saline 10-20 ml before and after infusion and as needed

Heparin 10 or 100 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 administration
- Administer IVig or teach SCIg administration
- Obtain vital signs prior to, throughout as directed and at completion of infusion
- Labs obtained
- Request Titration rate: If reaction occurs follow procedure for reaction management

REACTION MANAGEMENT*

*Items will be replaced as needed

Diphenhydramine 25-50 mg IV PRN; Disp 1 vial NaCl 0.9% 500 ml IV PRN; Disp 1

Epinephrine 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

Bysigning 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 _____