vitalcare of MERIDIAN

Pharmacy Name: Vital Care of Meridian
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Immune Deficiency Immunoglobulin Therapy

To	From	Number of Pages including Cover
Intake Phone	Phone	Fax
Patient Name	**DOB**	**Date**
Allergies	**Height**	**Weight**

Rx: Intravenous Route

IVIG _____ grams daily for _____ day(s) OR IVIG _____ grams/kilogram daily given over _____ non-consecutive day(s)
Repeat course every _____ week(s) for a total of _____ course(s) Dose will be rounded to nearest vial size.

Rx: Subcutaneous Route

IG_____ grams each month given as_____ doses OR IG _____ grams _____ times per month. Administer SCIG using _____ sites at a time. Repeat _____week(s). Ok to round dose to nearest vial size. Refill x 1yr.

Diagnosis	ICD-10	Diagnosis	ICD-10
☐ Common Variable Immunodeficiency with Predominant Immunoregulatory T-Cell Disorders	D83.1	☐ Selective deficiency of Immunoglobulin M [IgM]	D80.4
☐ Wiskott-Aldrich Syndrome	D82.0	☐ Selective deficiency of Immunoglobulin G [IgG] Subclasses	D80.3
☐ Combined Immunodeficiency, Unspecified	D81.9	☐ Hereditary Hypogammaglobulinemia	D80.0
☐ Severe Combined Immunodeficiency [SCID] with Low T- and B- Cell Numbers	D81.1	☐ Immunodeficiency with Increased IgM	D80.5
☐ Severe combined Immunodeficiency [SCID]with Low or Normal B-Cell Numbers	D81.2	☐ Other Common Variable Immunodeficiencies	D83.8
☐ Selective deficiency of Immunoglobulin A IgA]	D80.2	☐ Common Variable Immunodeficiency, Unspecified	D83.9

Other:

IV Access Device ☐ Peripheral ☐ Central

Hydration: Infuse 500 mL of NS. Start at 100ml/hr 30 minutes before the IVIG starts; then run concurrently with IVIG infusion.

Medi-Cal ID# ☐ Refill x 1Year

Per Home Care Services recommendation:

☐ -ACETAMINOPHEN 650 MG (325mg X 2) orally PRE-IVIG
☐ -DIPHENHYDRAMINE 25 MG orally PRE-IVIG
☐ None
☐ Other premed orders:_____
☐ Other premed orders:_____
☐ Other premed orders:_____
☐ Epi-Pen 0.3mg 2-Pak Auto-Injector

If applicable, flush intravenous access device per Home Care Services protocol:

Access	NS	Heparin 100 u/mL
Peripheral	1 - 3 mL before/after use	1 - 3 ml after last NS
Midline, Central (Non-Port), PICC	3 - 5 mL before/after use 5 - 10 ml after blood draw	3 - 5 ml after last NS
Implanted Port	5 - 10 mL before/after use 10 - 20 ml after blood draw	5 ml after last NS
Groshong PICC, Midline	5 - 10 mL before/after use 10 - 20 mL after blood draw	None

If needed, a Basic Metabolic Panel (Chem 7) to be drawn prior to first dose. If necessary Patient may have first dose administered in the home by a skilled nurse, unless instructed otherwise. Pharmacy to provide all equipment and medical supplies necessary to administer therapy as appropriate.

Prescriber Signature:	**Date**
Print Prescriber Name	**NPI#**

Please fax the following information:

☐ Immunoglobulin order – include dose, route of administration, frequency, duration, and any pre-medications OR use prescription order section above
☐ Patient demographics – include insurance information. **We will obtain authorization** unless the insurance dictates otherwise
☐ H & P **OR** progress note(s) describing diagnosis and clinical status
☐ Labs – BUN/Creatinine (preferred within last 90 days), Immunoglobulin Panel

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature: _____

Date: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

The attached document(s) contain confidential information which may be considered to be Protected Health Information and therefore required to be maintained as private and secure under HIPAA. The documents may also contain information which is otherwise considered to be privileged under state and federal laws. This communication is for the intended recipient only. If you are not the intended recipient, or a person responsible for delivering this communication to the intended recipient, you are prohibited from viewing, copying and/or distributing the information contained herein. Unlawful disclosure of the information attached may subject you to monetary penalties and sanctions. If you have received this communication in error, you should notify the sender immediately and thereafter permanently destroy all copies of this document in its entirety.

This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.

This is not a valid prescription in the state of Arizona.