Beacon Infusion
Healthcare Services

Headquarters Location:
1075 Stephenson Ave, Suite D-2, Oceanport, NJ 07757
Telephone: (833) 223-2266 Fax: (732) 329-2322

IVIG MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ **DOB:** _____

■ Diagnosis

Please provide the diagnosis as well as the most specific ICD-10 code available: _____

■ Details Needed for Authorization

Patient's height in ft/in: _____ **Patient's weight in lbs: _____**

- Recent laboratory results including patient's IgG levels. Other disease-specific labs should be included (eg. platelet count with ITP).
- Chart should include history of difficult-to-treat infections, deficiency in producing antibodies in response to vaccination, etc.

■ Premedication Order

Oral medications to be taken by the patient at least 60 minutes prior to start of infusion treatment. May be taken at home:

☐ Acetaminophen ____mg ☐ Diphenhydramine ____mg ☐ Cetirizine ____mg

IV medications to be administered prior to start of the infusion treatment (for infusions only, not for injections):

☐ Dexamethosone ____mg ☐ Famotidine _____mg ☐ Methylprednisolone _____mg
☐ Diphenhydramine ____mg ☐ Metoclopramide _____mg ☐ _____

■ IVIG Order

☐ Bivigam ☐ Flebogamma ☐ Gammaplex ☐ Panzyga
☐ Carimune ☐ Gammagard Liquid ☐ Gamunex-C ☐ Privigen
☐ Cutaquig ☐ Gammaked ☐ Octagam

☐ Please check here only if we may NOT substitute your IVIG brand of choice, depending on brand availability and allocation limitations.

Dose: _____ mg/kg *If treatment is split over a few visits, list the dose per visit. So if it is 2,000mg/kg total over 4 infusions, it should be listed as 500 mg/kg here.*

Rate

☐ _____ ml over _____ minutes
☐ Start at _____ ml/hr, after _____ minutes increase to _____ ml/hr, after _____ minutes increase to _____ ml/hr, after _____ minutes increase to _____ ml/hr, after _____ minutes increase to _____ ml/hr.

Volume

☐ _____ ml of normal saline ☐ _____ ml of half normal saline ☐ _____ ml of D5W

Frequency: To be administered _____ for _____. *(example: 4 consecutive days per month, for 1 year)*

☐ If filtered tubing is required, indicate particle size filter to be used: 0.2µ or 1.2µ

After the infusion is complete, flush with normal saline. Check vitals and monitor for signs and symptoms of an infusion reaction at start, throughout infusion, and after completion.

■ Rescue Management in case of Infusion Therapy Reaction

Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction. Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed. For severe reactions, administer Epi-pen or equivalent and call 911.

■ Ordering Provider Authorization

Provider's Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone Line to Contact Person: _____

STANDARD DOCUMENTATION TO INCLUDE:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

Fax this order and supporting documentation to (732) 329-2322.