Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy

P: (360) 933-4892
F: (360) 933-1197
www.infusionsolutionsinc.com

SUBCUTANEOUS IMMUNE GLOBULIN (SubQ IG) ORDER FORM

PATIENT NAME: _____ DOB: _____ WT: _____ HT: _____

ALLERGIES: _____

DIAGNOSIS

HAS THE PATIENT PREVIOUSLY RECEIVED: Immune globulin therapy (IV or SubQ) ❒NO ❒YES

LAST BRAND/DOSE RECEIVED: _____ LAST DOSE DATE: _____

DIAGNOSIS: _____ ICD 10 CODE(S): _____

MEDICATION ORDERS

DOSE: _____ grams/kg **OR** _____grams (total dose)

Brand will be selected by pharmacy, unless specified. ❒Specific brand (if medically necessary): _____

FREQUENCY: Give SubQ every: _____ Other instructions: _____

PHARMACY USE ONLY

Pharmacist will use actual body weight (ABW) or adjusted body weight (adjBW) if ABW is >30% more than the ideal body weight (IBW) unless prescriber indicates otherwise.

ABW = _____ kg IBW = _____kg If applicable, adjBW (IBW+0.4[ABW-IBW]) = _____kg

Final dosing weight: _____ kg

Calculated SubQ IG dose: _____ RPh initial/date: _____

PREMEDICATION: 15 to 30 minutes prior to infusion

❒Acetaminophen 1000 mg PO ❒Diphenhydramine 25 mg PO ❒Other (dose/route): _____

STANDARD ORDERS

ANCILLARY ORDERS:

- Infusion Reaction Management per Infusion Solutions Protocol.
- Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- Flush with 0.9% NaCl and/or Heparin 10 u/ml or 100 u/ml per Infusion Solutions protocol.
- Lidocaine 1% - up to 0.2 ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).

NURSING ORDERS:

- Obtain weight before each dose
- Monitor vital signs (temp, HR, RR, BP) before therapy, and every 15-30 minutes or with each rate change.
- If an infusion reaction occurs, decrease rate AND monitor vital signs until symptoms subside. If the reaction persists or worsens, stop the infusion, initiate reaction protocol, and notify prescriber.
- Observe patient for 30 minutes after completion of therapy.

LABS

LAB ORDERS:

❒Serum creatinine

❒Other: _____

LAB FREQUENCY:

❒Every 3 months

❒Other: _____

REQUIRED DOCUMENTATION

REQUIRED CLINICAL DOCUMENTS:

- None

RECOMMENDED CLINICAL DOCUMENTS (provide if available):

- Baseline labs: CMP, CBC w/ diff, IgG, IgA levels

SUPPORTING DOCUMENTS:

- Patient demographic and insurance information.
- Copy of front and back of insurance card if available.
- Patient's medication list.
- Supporting clinical notes, including past tried and/or failed therapies.

PROVIDER INFORMATION

PRESCRIBER SIGNATURE (substitution) *PRESCRIBER SIGNATURE (dispense as written)*

PRINT NAME (FIRST AND LAST) *DATE*