

Immune Deficiency Immunoglobulin Therapy

To Vital Care of Tampa	From	Number of Pages including Cover
Intake Phone 813-632-8545	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 SQIG using _____ sites at a time. Repeat _____ week(s). Ok to round dose to nearest vial size. Refill x 1yr.

Diagnosis	ICD-9	ICD-10	Diagnosis	ICD-9	ICD-10
<input type="checkbox"/> Common Variable Immunodeficiency with Predominant Immunoregulatory T-Cell Disorders	279.10	D83.1	<input type="checkbox"/> Selective deficiency of Immunoglobulin M [IgM]	276.02	D80.4
<input type="checkbox"/> Wiskott-Aldrich Syndrome	279.12	D82.0	<input type="checkbox"/> Selective deficiency of Immunoglobulin G [IgG] Subclasses	279.03	D80.3
<input type="checkbox"/> Combined Immunodeficiency, Unspecified	279.2	D81.9	<input type="checkbox"/> Hereditary Hypogammaglobulinemia	279.04	D80.0
<input type="checkbox"/> Severe Combined Immunodeficiency [SCID] with Low T- and B- Cell Numbers		D81.1	<input type="checkbox"/> Immunodeficiency with Increased IgM	279.05	D80.5
<input type="checkbox"/> Severe combined Immunodeficiency [SCID]with Low or Normal B-Cell Numbers		D81.2	<input type="checkbox"/> Other Common Variable Immunodeficiencies	279.06	D83.8
<input type="checkbox"/> Selective deficiency of Immunoglobulin A IgA]	279.01	D80.2	<input type="checkbox"/> Common Variable Immunodeficiency, Unspecified		D83.9
			<input type="checkbox"/> 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: Epinephrine 0.3 mg vial x 2
- 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.