SPECIALTY INFUSION

TRANSPLANT ORDER FORM

Torrance, CA **toll free** 866.202.9552 **toll free fax** 866.794.4844
krogerspecialtyinfusion.com

DATE: _____ NEEDS BY DATE: _____

PATIENT INFORMATION

Patient Name		Parent/Guardian *(if applicable)*	❑ All Insurance Info Attached
Address		City	State Zip
Main Phone	Alternate Phone	Email Address	
Date of Birth	❑ Male ❑ Female	Height *(required)* inches	Weight *(required)* pounds
Other Drugs Used to Treat Patient's Condition		First Dose of IVIg: ❑ Yes ❑ No	Prior Ig Products Tried
Adverse Reactions with Previous Ig Treatments		Allergies	❑ NKDA

DIAGNOSIS

❑ V42.0 Kidney Transplant ❑ V42.1 Heart Transplant ❑ V42.6 Lung Transplant ❑ Other *(ICD-10 and description)*: _____

Please include the following information:
❑ Demographics ❑ H&P ❑ Physician Orders ❑ Insurance Information ❑ Labs

PRE-MED ORDER – 30 MINUTES PRIOR TO INFUSION

Diphenhydramine: _____ mg orally Acetaminophen: _____ mg orally
Prednisone: _____ mg orally Other Meds: _____

IVIG ORDER

Infuse IVIG: _____ grams or _____ gm/kg IV over _____ hours as tolerated
Frequency: _____ **Duration:** _____
❑ Pharmacy to Select IVIG Product ❑ No IVIG Requested

RITUXAN ORDER

❑ If patient is greater than 1.5m^2 infuse: Rituxan 1gm IV one time only on day _____ of infusion protocol
❑ If patient is less than 1.5m^2 infuse: Rituxan 375mg/m^2 IV one time only on day _____

Infusion Rate: ❑ Over _____ hours
❑ Initial rate of 50mg/hr, may increase infusion rate by 50mg/hr increments every 30 minutes to maximum of 400mg/hr if no hypersensitivity or infusion related events develop.

Diluent: ❑ Normal Saline ❑ D5W
Final Concentration: ❑ 1mg/ml ❑ 2mg/ml ❑ 4mg/ml ❑ No Rituxan Requested

LAB WORK ORDERS

❑ BUN and Serum Creatinine Fax results: ❑ Prior to first infusion ❑ After _____ infusion
❑ Other: _____ Fax results: ❑ Prior to first infusion ❑ After _____ infusion

PHYSICIAN INFORMATION

Physician Name: _____ License: _____
Address: _____ DEA: _____
City: _____ State: _____ Zip: _____ NPI: _____
Phone: _____ Fax: _____ Office Contact *(required)*: _____

By signing this form and utilizing our services, you are authorizing Kroger Specialty Infusion and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Dispense As Written Date Prescriber's Signature (no stamps) Substitution Permitted Date

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