SPECIALTY INFUSION

IMMUNE GLOBULIN
PRIMARY IMMUNE DEFICIENCY

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

KROGER SPECIALTY INFUSION REPRESENTATIVE: _____

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	

CLINICAL INFORMATION - PRIMARY DIAGNOSIS - ICD-10

❑ Common Variable Immunodeficiency (CVID) ICD-10 _____
❑ Combined Immunity Deficiency & SCID ICD-10 _____
❑ Congenital Hypogammaglobulinemia ICD-10 _____
❑ Hypogammaglobulinemia ICD-10 _____
❑ Immunodeficiency with Increased IgM ICD-10 _____
❑ Selective IgM Immunodeficiency ICD-10 _____
❑ Selective Ig Immunodeficiency ICD-10 _____
❑ Other: _____ ICD-10 _____

PRESCRIPTION AND ORDERS

Administer: ❑ SCIG ❑ IVIG **Product:** ❑ Pharmacist to determine (or) ❑ Forumulation: _____

Dose: *(please select option(s) and provide complete information, pharmacy to round the nearest 5 gram vial)*
❑ **Loading Dose:** _____ gm/kg OVER _____ day(s), then ❑ **Maintenance Dose:** _____ gm/kg OVER _____ day(s) EVERY _____ week(s) x _____ cycle(s)
❑ **Other Regimen:** _____

Infusion Rate: *(please select one and provide complete information)*
❑ Pharmacist to determine
❑ Start at _____ mL/hr, then increase by _____ mL/hr every _____ minutes to maximum rate _____mL/hr

Access: ❑ Peripheral ❑ PICC ❑ Port ❑ Other: _____

IV Maintenance (Flushing): Dispense Quantity Sufficient
- Sodium Chloride 0.9% 10mL Prefilled Syringe: Flush IV access device with sodium chloride 3-10mL to maintain line patency.
- Heparin 10 units/mL 5mL Prefilled Syringe: Flush peripheral IV access device with Heparin 10 units/mL 1-5 mL as needed to maintain line patency.
- Heparin 100 unit/mL 5mL Prefilled Syringe: Flush central IV access device with Heparin 100 units/mL 3-5 mL as needed to maintain line patency.

Adverse/Anaphylactic Reactions: Anaphylaxis kit to be used in the event of anaphylactic reaction and will contain the following:
- Diphenhydramine 25mg Capsule #2
- Diphenhydramine 50mg/mL 1mL vial #1
- Sodium Chloride 0.9% 500mL Bag #1
- Epinephrine Injection Auto-Injector 0.3mg (>30kg pt) or 0.15mg (<30kg pt) Two-Pack #1
- Sodium Chloride 0.9% 10mL Prefilled Syringe #4

Pre-Treatment: Dispense Quantity Sufficient
Acetaminophen 325mg Tablet: 1-2 tablets by mouth 15-30 minutes before each infusion. ❑ Decline
Diphenhydramine 25mg Capsule: 1-2 capsules by mouth 15-30 minutes before each infusion. ❑ Decline
❑ Other: _____

Ancillary Supplies: Dispense ancillary supplies and equipment needed to provide home infusion therapy.

Labs: Results will be faxed to physician's office. If no frequency noted, ordered labs to be done prior to initial infusion only. Labs will not be drawn on weekends or holidays. Not appropriate for STAT labs.
Labs to be Drawn: _____ Frequency of Labs: _____

Nursing Orders for Home Infusion MONITOR (IV Only)

Observe: Vital signs prior to infusion. Blood pressure and pulse every 15 minutes for first hour, then every 30 minutes until stable infusion rate, then every hour.

Watch for: Signs of fluid overload, cardiovascular symptoms, allergic reactions, skin rash, fever, and moderate to severe headache.

Call/Page MD: For adverse events, stop the infusion. Can restart the infusion at the same or lower rate pending physician's approval or if symptoms subside.

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