

Patient Demographics:		Clinical Information:	
Name _____	DOB _____	Ht. (in/cm) _____	Wt. (lb/kg) _____
Address _____	Last 4-SSN _____	ICD-10 Code _____	
City, ST Zip _____	Language _____	Allergies _____	
Phone* _____	Alt. Phone* _____	Access ☐ PIV ☐ CVC/PICC ☐ Port ☐ None SC	
☐ patient support program info requested			

Date Medication Needed:	Site of Care:	Nursing:
	☐ Home Infusion ☐ Coram Ambulatory Infusion Suite (AIS) ☐ Prescriber office or other infusion clinic (drug only)	Specialty pharmacy will coordinate home infusion nursing for administration. Patient may be taught to self-infuse (SC). ☐ OK to administer first dose in the home if pharmacist deems appropriate

Rx Information: Pharmacist to identify clinically appropriate Ig brand and rate per FDA guidelines. Clinically appropriate substitutions allowed based on availability or payor requirements. IV and SC dose rounded to the nearest vial size. May infuse +/- 4 days per patient schedule requests.

Drug: Immunoglobulin Route: ☐ SC ☐ IV Dose: _____ grams or _____ mg/kg daily x _____ day(s), every _____ week(s) _____
 Other (Preferred Product): _____

Additional Rx Info (Home or Coram AIS): Rx includes related diluents, pumps, DME, ancillary supplies as necessary for drug administration/catheter maintenance.

Pre/Post Orders:	Dosing Protocols			Route	Directions
Normal saline hydration □ Other: _____	Pre: _____ mL	Concurrent: _____ mL Not to be infused using the same access as Ig	Post: _____ mL	IV	Administer _____ mL/hr or over _____ hours (max rate 250mL/hr and administer via gravity unless otherwise specified)
Diphenhydramine	□ 25 □ 50 mg (May be instructed to purchase at retail.)			PO	30 minutes prior to infusion
Acetaminophen	□ 325 □ 500 □ 650 □ 1000 mg (May be instructed to purchase at retail.)				
Other:					

Catheter Maintenance: Dispense and administer based on patients' current access device unless otherwise specified. Access will be PIV unless otherwise specified. Nurse to administer PIV if Port or PICC failure.

	PIV	CVC/PICC	PORT	IV	Administer only on drug admin days before and after drug administration, PRN to maintain IV access patency or obtain labs.
Saline Flush	3-5 mL	10 mL	10 mL sterile to access 10 mL Before & After		
Heparin Flush	3 mL-10 units/mL if multiple days	3-5 mL 100 units/mL excludes groshong	3-5 mL 100 units/mL		
Other:					

Anaphylaxis Orders (AIR): Dispense and administer based on current weight unless otherwise specified. Epinephrine autoinjector dispensed when self-administering.

Epinephrine	Adult (>30 kg)	Pediatric (15-30kg)	Infant (<15kg)	IM/SC	Administer 1 dose for moderate to severe allergic reaction. May repeat in 3-5 mins PRN
	0.3 mg	0.15 mg	0.01 mg/kg (Max 0.3mg)		
Diphenhydramine	25-50 mg	1.25 mg/kg	1.25 mg/kg	PO	Administer x 1 dose PO for mild reaction or 1 dose slow IV/IM for moderate to severe reaction. May repeat in 3-5 mins PRN. Max dose of 50mg.
	25-50 mg	12.5 to 50 mg	1 mg/kg	IV/ IM	

AIR PROCEDURE: STOP any infusion or medication administration immediately and maintain IV access device. Assess patient response. If reaction subsides, resume infusion at ½ previous rate and increase gradually to a rate no > previous rate. If moderate to severe symptoms occur, activate EMS and initiate BCLS, O2, and AIR medications if indicated. Contact Prescriber for additional medical management if indicated. If reaction does NOT subside, continue to follow BCLS & remain with patient until EMS arrives.

Lab Orders (Home or Coram AIS only):	Qty: 1 month ☐ Other _____	Refills: 1 year ☐ Other _____
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Prescriber signature required (stamp not allowed): Prescriber attests to supervising this patient's medically necessary treatment.

Prescriber Name _____	NPI _____	Phone _____
State License _____	DEA _____	Fax _____
Group / Hospital _____		Contact Person _____
Address, City, ST Zip _____		Contact Phone _____
☐ Dispense As Written / ☐ Brand Medically Necessary / ☐ Do Not Substitute / ☐ No Substitution / ☐ DAW / ☐ May Not Substitute		☐ May Substitute / ☐ Product Selection Permitted / ☐ Substitution Permissible

Prescriber's Signature: _____ **Date:** _____ **Prescriber's Signature:** _____ **Date:** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." **NY & IA:** electronic prescription required.