IVIG / SCIG ENROLLMENT

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ALTHEA
INFUSION & SPECIALTY PHARMACY™

Patient Name: _____ **DOB:** _____ **Height:** _____ **Weight (kg):** _____ **Date:** _____

Allergies: _____ **Email:** _____ **Phone:** _____

Address: _____ **Ship to:** ☐ Patient ☐ MD Office ☐ Althea Location

DIAGNOSIS (ICD-10) — check all that apply

- ☐ D80.1 – Nonfamilial Hypogammaglobulinemia
- ☐ D80.2 – Selective Deficiency of IgA
- ☐ D83.0 – Common Variable Immunodeficiency (CVID)
- ☐ D80.3 – Selective Deficiency of IgG
- ☐ D69.3 – Immune Thrombocytopenic Purpura (ITP)
- ☐ G61.81 – CIDP
- ☐ G70.00 – Myasthenia Gravis
- ☐ G35 – Multiple Sclerosis (RRMS)
- ☐ G61.0 – Guillain-Barre Syndrome
- ☐ G61.82 / G25.82 – Multifocal Motor Neuropathy / Stiff-Person
- ☐ L10.0 – Pemphigus Vulgaris
- ☐ Other: _____

IVIG / SCIG PRESCRIPTION

IVIG Brand: ☐ Octagam 5% ☐ Octagam 10% ☐ Panzyga 10% ☐ Privigen 10% ☐ Gammagard 5% ☐ Gammagard 10% ☐ Gamunex-C 10%

Route: ☐ IVIG ☐ SCIG **Preferred Brand:** ☐ Pharmacist to determine ☐ Specify: _____

Product: _____ **Dose:** _____ g/kg **Frequency:** _____ **Qty:** _____ ***Refills:** _____

Substitution Permitted: ☐ Yes ☐ No **Infuse Over:** _____ days **Max Rate:** _____ cc/hr

PREMEDICATION ORDERS

Given 30–60 min prior to infusion. Flush per S.A.S.H. protocol (Saline, Administer med, Saline, Heparin) per line type.

Refills entered in the IVIG/SCIG Prescription section above also apply to premedications.

☐ Acetaminophen _____ mg PO ☐ Diphenhydramine _____ mg PO/IV ☐ Methylprednisolone _____ mg PO/IV

☐ Other: _____

ANAPHYLAXIS KIT & HYDRATION STANDING ORDERS

Authorizes RNs/LVNs to administer the following without a separate patient-specific order, per protocol, for 1 year from signature date.

Anaphylaxis Kit — check to authorize:

- ☐ Epinephrine 1:1000, 0.3 mg IM; may repeat q5-15 min PRN
- ☐ Sodium Chloride 0.9%, 500 mL IV bolus x1
- ☐ Methylprednisolone 125 mg IV push x1
- ☐ Diphenhydramine 50 mg IV or IM x1

Hydration Kit — base fluid always given; check to remove:

Base: Sodium Chloride 0.9%, 500 mL IV over 30 min

- ☐ Remove Vitamin B-12 1,000 mcg
- ☐ Remove Calcium Gluconate 180 mg
- ☐ Remove Magnesium Chloride 800 mg
- ☐ **DO NOT INFUSE hydration kit for this patient**

Infusion Reaction Protocol — check to authorize:

Vitals per protocol: prior to infusion, q15 min during rate escalation, hourly thereafter, and at completion. Watch for dyspnea or rash.

For any reaction: stop infusion and administer meds as applicable, then notify prescriber.

- ☐ Acetaminophen 325 mg PO for headache, temp > 101°F
- ☐ Methylprednisolone IV for persistent or severe reaction
- ☐ Diphenhydramine 25 mg PO or Loratadine 10 mg PO for itching/rash

If symptom resolves, resume treatment at 50% rate after 30 min, then titrate to patient tolerance. If severe/symptomatic, do not restart.

CLINICAL PARAMETERS & HOLD CRITERIA

Hydration Kit — do NOT infuse if:

Vitals: SBP > 160, DBP > 100, or HR > 100 bpm
Labs: Ca > 10.5, Mg > 2.6, eGFR < 90, or BNP > 100
Pregnancy/breastfeeding; signs of CHF, ESRD,
liver cirrhosis, or shortness of breath/edema

Anaphylaxis — initiate immediately if rapid onset of:

Respiratory: wheezing, stridor, throat tightening,
or SpO2 < 92%
Circulatory: SBP < 90 (or drop > 20 w/ symptoms),
HR > 110, or syncope
Skin/GI: angioedema, generalized hives, severe cramps

Emergency sequence: Stop infusion (keep IV access) → Call 911 → Give epinephrine IM → Do not restart infusion → Monitor vitals q1–2 min, transport via EMS, and notify prescriber and pharmacy in SBAR format once stable.

PRESCRIBER AUTHORIZATION

By signing below, I authorize Althea Infusion & Specialty Pharmacy to dispense the IVIG/SCIG prescription above, and I authorize California-licensed RNs to administer the Anaphylaxis Kit and Hydration Kit standing orders as indicated above. I assume clinical responsibility for these orders, which remain in effect for 1 year from the date below or until rescinded by me in writing.

Prescriber Name: _____ **NPI:** _____ **DEA:** _____ **CA Lic:** _____

Phone: _____ **Fax:** _____ **Specialty:** _____

Prescriber Signature: _____ **Date:** _____