KAISER PERMANENTE®

**Kaiser Permanente Washington Home Infusion Pharmacy (KPWAHIP)**
**IVIG Prescription Referral Form**
Phone: (206) 326-2990 **Fax Referral To: (206) 326-2139**

## 1 PATIENT INFORMATION

**Patient Name:** _____
**Phone:** _____
**Address:** _____
**City:**_____ **State:** _____**Zip:**_____
**MRN #:** _____
**DOB:** _____
**Drug Allergies:** _____

## 2 PRESCRIBER INFORMATION

**Prescriber's Name:** _____
**DEA#:** _____ **NPI:** _____
**Clinic/Facility Name:** _____
**Address:** _____
**City:** _____ **State:** _____ **ZIP:** _____
**Phone:** _____ **Fax:** _____

## 3 Instructions to Provider

All orders with ✓ will be placed unless otherwise noted. Please fax completed order form to 206-326-2139. For drug prior authorization, call 1-888-767-4670 or visit https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/preservice.

## 4 CLINICAL INFORMATION

**Diagnosis (ICD-10 code)**: _____ **Date of Last Dose:** _____

## 5 IVIG PRESCRIPTION INFORMATION

**Select the IVIG Product: [ ] Gammagard Liquid 10% (preferred) [ ] Gamunex-C 10% [ ] Privigen 10%**

**First Dose:** □ No □ Yes **Weight:** _____ **Date Recorded:** _____
**Quantity**: □ 1 month supply □ Other _____
**Dose in mg/kg (optional):** _____ **Dose (**grams) and frequency: _____
**Refills:** □ 11 months □ Other ____
**Infusion Access:** □ PIV □ CVAD □ Other: _____
**Patient's Current Home Care/Specialty Pharmacy:** _____ _____

**Infusion Reaction Medications & Supplies**

- ✓ **Hydrocortisone sodium succinate injectable 100 mg IV**
  **Sig:** Once PRN for hypersensitivity
- ✓ **Epinephrine Auto-Injector** □ 0.15mg □ 0.3mg **QTY**: 2
  **Sig:** Inject into lateral thigh muscle for severe allergic reaction. Seek medical attention after use.
- ✓ **Diphenhydramine injectable 25 mg IV**
  **Sig:** Once PRN, may repeat x1 for urticaria, pruritis, shortness of breath
- ✓ **Sodium Chloride 0.9% IV 250 ml Bag**
  **Sig:** Once PRN for anaphylaxis
- ✓ **Sodium Chloride 0.9% IV Flush**: Flush 10 ml IV before/after medication administration or as needed for line maintenance

**Labs /Special Instructions/Pre-meds:** _____
_____
_____

**Infusion Protocol:**

- Infuse per manufacturer guidelines
- Monitor vital signs (Temp, BP, HR, RR) every 15 minutes x 4; then every 30 minutes x2; then every 60 minutes until completion of infusion
- Documentation must include:
  - Start and end time of infusion
  - All rate changes, vital signs, including initial and final set
  - Patient response
- Observe patient for signs of infusion rate-related adverse reactions:
  - Blood pressure changes, increased pulse rate
  - Fever, chills
  - Headache
  - Chest, back or hip pain
  - Dyspnea
  - Mild erythema

## 6 PHYSICIAN SIGNATURE REQUIRED

| X | X |
|---|---|
| *SUBSTITUTION PERMITTED* *(Date)* | DISPENSE AS WRITTEN (Date) |


**Members with Medicare Part B or D coverage are not required to use this form.**