BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

IMMUNOGLOBULIN (IG)
IV AND SUBQ ORDERS

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT INFORMATION:
Fax completed form, insurance information, and clinical documentation to 470.922.3656

Patient Name: _____ DOB: _____ Phone: _____
Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Date of last infusion:**

MEDICAL INFORMATION

ICD-10 Code (required): _____ **ICD-10 description**: _____

Patient Wt: _____ kg Height: _____ Diabetic ☐ Yes ☐ No If obese, use adjusted body wt? ☐ Yes ☐ No

Allergies: _____ Brand previously used: _____

THERAPY ORDER

☐**IV** ☐ **SubQ** **Pharmacist to identify clinically appropriate brand/infusion rates. May substitute based on product availability.**

Loading Dose *(as applicable)*	_____	☐mg/kg ☐gm/kg ☐grams	x ___ day(s) **OR** divided over ___ day(s)	☐One time dose ☐Other: _____ * *Give maintenance dose ___ weeks after loading dose**
Maintenance Dose	_____	☐mg/kg ☐gm/kg ☐grams	x ___ day(s) **OR** divided over ___ day(s)	☐Q _____ weeks x1 year ☐Other: _____

☐Do not substitute. Administer brand: _____

- Infuse entire contents of Ig infusion bag/vial(s) per current dose.
- If needed, round dose to nearest whole 5 gm vial for IV doses and nearest single-use vi al size for subQ doses.

Pre-Medication Orders: *to be administered 15-30 minutes before infusion*

☐Acetaminophen 500mg PO ☐Normal Saline 500mL IV ☐Cetirizine 10mg PO
☐Solu-Medrol _____ mg IVP ☐Diphenhydramine 25mg PO ☐ Quzyttir 10mg IVP
☐Loratadine 10mg PO ☐Diphenhydramine 25mg IV ☐Other: _____

Lab Orders: _____ **Lab frequency:** ☐ Each infusion ☐ Other: _____
Required labs to be drawn by ☐ Biocare Infusion ☐ Referring Provider

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen ® 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x 1
  - 15-30kg (33-66lbs): EpiPen ® 0.15mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x 1
- Diphenhydramine - Administer 25-50mg orally OR IV (adult), refer to provider orders or policy for pediatric dose
- NS 500 mL IV bolus as needed for IVIg therapy (adult), refer to provider orders or policy for pediatric bolus

Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

*FOR BIOCARE INFUSION USE ONLY

Drug/Brand Selection: _____ Date: _____
NP/Pharmacist Name: NP/Pharmacist Signature:

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Biocare Infusion,* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient

Provider Name: _____ Signature: Date: _____
Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____
☐Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

BIOCARE INFUSION
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COMPREHENSIVE SUPPORT FOR IMMUNOGLOBULIN THERAPIES

REQUIRED DOCUMENTATION FOR INSURANCE APPROVAL
GENERAL REQUIREMENTS

- Patient demographics
- Insurance information
- All applicable diagnoses
- History and physicial
- Recent progress notes within 12 months
- Patient's height and weight
- Drug allergies
- Physician Orders
- Plus one of the following

COMMON VARIABLE IMMUNODEFICIENCY (CVID) / HYPOGAMMAGLOBULINEMIA / PARKINSON'S DISEASE (PD)

- Lab last showing Ig levels and subclasses Ig levels.
- Documentation of recurrent infections
- History of antibiotic usage - showing failure to respond to antibiotics
- Documented inadequate response to pneumococcal vaccine or tetanus/diphtheria

CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP) / GUILLAIN-BARRÉ SYNDROME (GBS)

- Labs
- Nerve conduction study, electromyography (EMG)
- Nerve and/or muscle biopsy (if available)
- Nerve conduction velocity (NCV) test results
- Tried and failed treatments
- Spinal tap (if available)

MYASTHENIA GRAVIS

- Exacerbation
- Any history of crisis
- Thymectomy
- Any symptoms that affect respiration, speech or motor function
- Tried and failed treatments