IMMUNE GLOBULIN – TRANSPLANT (PEDIATRICS) PRESCRIBER ORDER FORM						
Fax completed form, insurance information, and clinical documentation to:						
INTELLIGENT	Patient Name:		Date of Birth:			
EHEALTH COMPANY.	Address:					
UBACARE	Phone:		Height:	☐ inches ☐ cm	Weight:	☐ lbs ☐ kg
Applicable Diagnosis: Kidney Transplant – Z94.0						86.0
Is this the first dose? ☐ Yes ☐ No – date of next dose due:						
Immune Globulin Prescription						
Immune globulin refill as directed x 1 year Infuse gm IV for day(s) every week(s) Infuse gm/kg (max gm/course) IV divided over day(s) every week(s) Other: Pharmacist to identify clinically appropriate IG brand and infusion rates. May substitute product based on product availability. Infuse entire contents of IG infusion bag/vial(s) per current dose. Round dose to nearest single-use vial. May infuse +/- 4 days to allow for patient scheduling.						
Ancillary Orders						
Anaphylaxis Kit → Required per Option Care Health policy — please complete Anaphylaxis Physician Order (FR-PC-036) provided. Pre-Medication Orders						
Acetaminophen mg PO 30 min before infusion. Patient may use own supply or patient may decline.						
 □ Diphenhydramine mg PO 30 min before infusion. Patient may use own supply or patient may decline. □ Other: □ Other: 						
IV Flush Orders Peripheral: NS 1 mL (2 to 20 kg) or 1 to 3 mL (> 20 kg) pre-/post-use and 1 to 3 mL (2 to 20 kg) or 3 to 5 mL (> 20 kg) pre-/post-use and 1 to 3 mL (2 to 20 kg) or 3 to 5 mL (> 20 kg) pre-/post-lab draw. Heparin (10 unit/mL) 1 mL (2 to 20 kg) or 1 to 3 mL (> 20 kg) post-use. NS 1 to 3 mL pre-/post-use and 3 to 5 mL pre-/post-lab draw. Heparin (10 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (10 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed. Skilled nurse to administer doses intravenously. Refill above ancillary orders as directed x 1 year.						
I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.						
Prescriber Signature: Date:						
Prescriber Name:		Phone:	F	ах:		
Address:			NPI:			
City, State: Zip:		Office Contact:				

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