

**BEAUMONT INFUSION CENTER
IMMUNOLOGY PRESCRIPTION**

Location / Fax # Royal Oak : 248- 551-3168 Troy : 248-964-2409 Lenox : 947-523-4061 Wayne : 734-467-2505
 Grosse Pointe : 586-498-4497 Farmington Hills : 248-471-8217 Dearborn : 313-593-5802 Livonia : 734-542-3356

Patient Name:	Date of Birth:	Medical Record #:
Physician Name:	Physician Address:	Physician Office #:
Anticipated Start Date for Care:	Diagnosis:	Diagnosis Code (ICD-10):

PATIENT INFORMATION: Please attach these required documents to Prescription (unless in EPIC):
 Copy of Insurance Card Labs Supporting clinical documentation Patient Demographics

NKDA Drug Allergies: _____

Height: _____ ft _____ in Weight: _____ kg / lbs Date: _____

PRESCRIBING RECOMMENDATIONS

***IVIG doses should be calculated utilizing IBW per Beaumont Health guidelines
Patients on established IVIG doses may continue the same dose.
Physician to fill in dose below, rounding to appropriate vial size.**

MEDICATION	DOSE
<p><u>NEGATIVE IgA ALLERGY HISTORY:</u></p> <p><input type="checkbox"/> PRIVIGEN 10% (PREFERRED)</p> <p><input type="checkbox"/> GAMUNEX-C 10%</p> <p><input type="checkbox"/> GAMMAGARD LIQUID 10%</p> <p><u>POSITIVE IgA ALLERGY: IgA < 0.05 g/L</u> Attach documented IgA level</p> <p><input type="checkbox"/> GAMMAGARD S/D 5%</p> <p><input type="checkbox"/> GAMMAGARD S/D 10%</p>	<p><input type="checkbox"/> _____ grams IV one time only</p> <p><input type="checkbox"/> _____ grams IV daily x _____ days</p> <p><input type="checkbox"/> _____ grams IV every _____ weeks x _____ doses</p> <p><input type="checkbox"/> _____ grams IV daily x 2 days every _____ weeks x _____ doses</p> <hr/> <p><u>Pre-medications:</u></p> <p><input type="checkbox"/> Acetaminophen 650mg PO 30 minutes prior to infusion</p> <p><input type="checkbox"/> Diphenhydramine 25mg PO 30 minutes prior to infusion</p> <p><input type="checkbox"/> Methylprednisolone _____ mg IVP 30 minutes prior to infusion</p>

Infusion Instructions (please indicate special instructions---unless specified, all IVIG infusions will be administered per manufacturer package insert):

- 250 ml 0.9% Sodium Chloride flush bag with infusion as needed.
- Treatment of Hypersensitivity / Anaphylaxis Adults - Protocol. Notify physician if reaction occurs.
- Flush IV with 10cc NS as needed.

Physician Signature _____ Beeper # _____ Date _____ Time _____