

Patient Name _____ SSN (last 4): _____ DOB _____ ☐ Male ☐ Female
Street Address _____ Apt/Unit# _____ City _____ State _____ Zip _____
Phone _____ Email _____ Preferred Language: ☐ English ☐ Spanish ☐ Other: _____
Emergency Contact: _____ Relationship: _____ Phone _____

****PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS****

Subscriber's Name _____ Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____
Policy Number _____ GROUP ID _____ BIN No. _____ PCN No. _____

ICD-10 Diagnosis: ☐ **N18.6** End-Stage Renal Disease ☐ **T86.810** Lung Transplant Rejection ☐ **T86.10** Unsp. Complications of Kidney Transplant
☐ **T86.811** Lung Transplant Failure ☐ **T86.11** Kidney Transplant Rejection ☐ **T86.812** Lung Transplant Infection ☐ **T86.12** Kidney Transplant Failure
☐ **T86.13** Kidney Transplant Infection ☐ **T86.819** Unsp. Complications of Lung Transplant ☐ **T86.19** Other Complications of Kidney Transplant
☐ **T86.81** Other Complications of Lung Transplant ☐ **Z94.2** Lung Transplant Status ☐ **Other ICD-10:** _____ **Description:** _____

Drug Allergies: _____ ☐ NKDA Height: _____ in/cm Weight: _____ lbs/Kg BSA (m²): _____
Blood Type: ☐ O- ☐ O+ ☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ **Medical History:** ☐ Diabetes ☐ Hypertension ☐ Other: _____
IgA Deficiency: ☐ *check box if patient requires low IgA product* **PRA Level:** _____ (attach copy of labs)
Dialysis Type: _____ **Dialysis Schedule:** _____
Previous Transplant History Dates: _____

PRESCRIPTION

PLEASE ATTACH: ☐ PATIENT DEMOGRAPHICS ☐ CLINICAL/OFFICE NOTES ☐ LABS.

PHYSICIAN ORDERS - Immunoglobulin therapy ☐ IVIG ☐ SCIG ☐ NOT REQUESTED

RX INFORMATION: Our pharmacist will identify clinically appropriate IG brand (Unless product is specifically specified at the time of referral) and infusion rate per FDA guidelines. Clinically appropriate substitutions may be allowed based on availability or payor requirements. Round IVig or SCIG dose(s) to the nearest vial size. Official orders will be outlined with "May Infuse" +/- 3 days if scheduling needs arise, with insurance payor approval".

Is this the first dose? ☐ Yes ☐ No If no: List Product: _____ Date of last infusion: ____/____/____ Next dose due: ____/____/____

Dose based on ☐ Actual Body Weight* ☐ Adjusted Body Weight* ☐ Ideal Body Weight*

☐ **Pharmacist to select IVIG/SCIG Product** ☐ **Specific Brand desired**, please specify: _____

LOADING DOSE: _____ grams TOTAL IV DOSE **OR** ☐ _____ mg/kg TOTAL dose over _____ admin days.

MAINTENANCE DOSE: _____ grams TOTAL IV DOSE **OR** ☐ _____ mg/kg TOTAL dose over _____ admin days. Repeat every _____ weeks.

IVIG PRE-MED ORDERS (30 to 60 minutes prior to infusion) ☐ No IVIG/SCIG Pre-Meds

☐ Acetaminophen (PO): Administer _____ mg orally 30-60 min Prior to Infusion. May repeat every _____ hours PRN.
☐ Loratadine (PO) **OR** ☐ Diphenhydramine: ☐ (IV) ☐ (PO) Administer _____ mg orally 30-60 min Prior to Infusion. May repeat every _____ hours PRN.
☐ Clonidine 0.1 mg orally for **BP ≥160/95** and May repeat x1 dose in one hour.
☐ Solu-Medrol (methylprednisolone sodium succinate): Administer _____ mg IV prior to infusion via ☐ IV push ☐ diluted in _____ mL of NS over 30 min.
☐ Hydration: Infuse _____ mL of ☐ 0.9% Sodium Chloride ☐ Lactated Ringer ☐ D5W solution before each infusion.

PHYSICIAN ORDERS - ☐ ACTEMRA (tocilizumab) **OR** Substitute to the Biosimilar: ☐ AVTOZMA ☐ TOFIDENCE ☐ TYENNE

Is this the first dose? ☐ Yes ☐ No If no: List Product: _____ Date of last infusion: ____/____/____ Next dose due: ____/____/____

Dose based on ☐ Actual Body Weight* ☐ Ideal Body Weight* *dose rounded to nearest vial size

☐ Infuse tocilizumab _____ mg **OR** ☐ _____ mg/kg in Sodium Chloride 0.9% 100 ml IV over 60 minutes. Repeat every _____ weeks.

PRE-MEDICATION ORDERS: (30 to 60 minutes prior to infusion) ☐ No tocilizumab Pre-Meds

☐ Acetaminophen (PO): Administer _____ mg orally. ☐ Solu-Medrol (methylprednisolone sodium succinate): Administer _____ mg IV push.
☐ Diphenhydramine: Administer ☐ (IV) ☐ (PO) _____ mg. ☐ Other: _____
☐ Loratadine (PO): Administer _____ mg orally.

PHYSICIAN ORDERS - RITUXAN (rituximab) **OR** Substitute to the Biosimilar: ☐ RIABNI ☐ RUXIENCE ☐ TRUXIMA

Is this the first dose? ☐ Yes ☐ No If no: List Product: _____ Date of last infusion: ____/____/____ Next dose due: ____/____/____

☐ Infuse rituximab _____ mg in _____ ml NS IV over 4 hours or as tolerated. Repeat every ☐ _____ weeks **OR** every ☐ _____ Months.

PRE-MEDICATION ORDERS: (30 to 60 minutes prior to infusion) ☐ No rituximab Pre-Meds

☐ Acetaminophen (PO): Administer _____ mg orally. ☐ Solu-Medrol (methylprednisolone sodium succinate): Administer ☐ 40 mg **OR** ☐ 125 mg IV push.
☐ Diphenhydramine: Administer ☐ (IV) ☐ (PO) _____ mg orally. ☐ Loratadine (PO): Administer _____ mg orally.

(PLEASE NOTE) Initial Dose: Patients who are "NAIVE" to rituximab or have been off of therapy for more than 365 days are **REQUIRED** to have two infusions (1 Cycle) done in a "Controlled Setting" prior to starting Home infusion.

COMPLETE PAGE 2 WITH CLINICAL INFORMATION

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX. **CONFIDENTIALITY NOTICE:** The information contained in this transmission may contain confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email to info@ivsolutionsrx.com and destroy all copies of the original message.

PRESCRIPTION

PLEASE ATTACH: ☐ PATIENT DEMOGRAPHICS ☐ CLINICAL/OFFICE NOTES ☐ LABS.

PHYSICIAN ORDERS - OTHER MEDICATIONS/THERAPIES

Medication/Drug Name: _____ Strength: _____ Dose: _____
 Frequency: _____ Route of Administration: _____

PRE-MEDICATION ORDERS: (30 to 60 minutes prior to infusion) ☐ No Pre-Meds

☐ Acetaminophen (PO): Administer _____ mg orally. ☐ Solu-Medrol (methylprednisolone sodium succinate): Administer _____ mg IV push.
☐ Diphenhydramine: Administer ☐ (IV) ☐ (PO) _____ mg. ☐ Loratadine (PO): Administer _____ mg orally.

ANAPHYLAXIS /FLUSH/SUPPLY ORDERS

IV Access: ☐ Peripheral ☐ Midline/PICC ☐ Port # of lumens: _____ Location: _____

Catheter Maintenance:

☐ Saline 0.9% Flush or D5W (determined by drug compatibility) 10mL syringe
☐ Heparin Flush 10units/mL – 5mL syringe ☐ Heparin Flush 100 units/mL – 5mL syringe

Flush Orders: Flush with Saline 0.9% or D5W 5-10mL prior to and after each dose of medication and PRN to check catheter patency.

For post lab work flush with 20mL saline 0.9%. Follow with Heparin 5 ml PRN for catheter maintenance (if required based on catheter type or if IV is left in place for subsequent infusion).

Anaphylaxis Orders: kit to be maintained in the home, monitored for expiration and replaced as needed.

- 1) STOP Infusion. 3) Administer medications below as per protocol.
- 2) Call 911 and Prescribing Physician. 4) Call IV Solutions RX.

☐ **EPINEPHRINE:** Administer via IM for severe anaphylactic reaction. May repeat one dose in 5-15 minutes. **Quantity:** ☐ 1 Vial OR ☐ 2 Auto-injector(s) | **Refills:** PRN
☐ **0.3 mg** (Wt > 30 kg) ☐ **0.15 mg** (Wt 15-30 kg) ☐ **0.1 mg** (Wt 7.5-15 kg)

☐ **DIPHENHYDRAMINE:** Administer via IM or slow IV push for severe anaphylactic reaction. **Quantity:** 1 Vial | **Refills:** PRN
☐ **50 mg** (Wt > 30 kg) ☐ **25 mg** (Wt 15-30 kg) ☐ **12.5mg** (Wt 7.5-15kg)

☐ **SODIUM CHLORIDE 0.9% (IV):** Infuse 500 mL IV as directed for severe anaphylactic reaction. **Quantity:** 500mL Bag | **Refills:** PRN

POST INFUSION MED ORDERS: (30 to 60 minutes POST infusion) ☐ No POST-meds

☐ Acetaminophen _____ mg orally PRN fever/headache.
☐ Diphenhydramine _____ mg orally PRN itching/rash/site reaction.
☐ Loratadine (PO): Administer _____ mg orally PRN itching/rash/site reaction.
☐ Hydration: Infuse _____ mL of ☐ 0.9% Sodium Chloride ☐ Lactated Ringers ☐ D5W solution after each infusion.
☐ Other: Medication/Drug Name: _____ Strength: _____ Dose: _____

LAB WORK ORDERS ☐ No lab work

☐ CMP ☐ CBC w/diff ☐ Creatinine Clearance ☐ BUN (**For Actemra IV**) ☐ Hep-B ☐ QuantiFERON Frequency: _____
☐ PRA Level ☐ Frequency: _____ **OR** ☐ Prior to 1st IVIG dose ☐ Monthly
☐ DSA Level ☐ Frequency: _____ **OR** ☐ drawn prior to 1st dose in the 6th month of treatment.
☐ Lab Draw Flushing protocol: 5mL Saline pre blood draw, 20mL Saline post blood draw.
☐ Additional Labs: _____
☐ Hold infusion(s) if: ☐ Hgb less than _____ ☐ Platelets less than _____ ☐ WBC less than _____

NURSING ORDERS

☐ Skilled nurse (SN) to provide care to complete therapy
☐ SN to provide education regarding: medication, disease state, signs and symptoms of complication/adverse drug reactions, infection control, safety, 24 hour on call availability, and emergency preparedness
☐ SN to place or access and maintain IV access according to INS standards and de-access or D/C when appropriate at completion of therapy.
 If port, PICC line or central line occluded patient may be accessed via peripheral line.
☐ **IV Access:** ☐ Peripheral ☐ Midline/PICC ☐ Port # of lumens: _____ Location: _____
☐ Baseline Vital Signs: BP, HR, Temp prior to infusion, every 15 min x 1st hour, with each rate change & subsequent hour until completion of therapy.
☐ SN to administer drug(s) as per physician's orders stated above
☐ SN can infuse via gravity if needed
☐ Observe for response to therapy
☐ Hold infusion(s) if: ☐ BP systolic above 180 mm Hg or _____ mm Hg **OR** ☐ BP diastolic above 105 mm Hg or _____ mm Hg.
☐ Nursing visit frequency: to cover number of days from frequency stated in physician orders above plus any lab draw days and PRN therapy related complications, catheter maintenance (dressing changes, access, etc.)

Prescriber Name: _____ ☐ MD ☐ DO ☐ PA ☐ NP ☐ APRN NPI: _____ TaxID: _____
 Address: _____ Unit/Suite/Floor _____ City/State/Zip: _____
 Phone: _____ Fax: _____ Contact Person: _____

☐ Dispense As Written ☐ Brand Medically Necessary ☐ Do Not Substitute ☐ No Substitution/ ☐ DAW / ☐ May Not Substitute ☐ May Substitute / ☐ Product Selection Permitted / ☐ Substitution Permissible

Prescriber's Signature: STAMP SIGNATURE NO ALLOWED **Date:** _____

Prescriber's Signature: STAMP SIGNATURE NO ALLOWED **Date:** _____

CA, MA & NC: Interchange is mandated unless Prescriber writes the words "No Substitution." **CA, DE, FL, IA, MI, MN & NY:** electronic prescription required. Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.