Ascension at Home | TOGETHER WITH COMPASSUS

IMMUNOGLOBULIN (IG) IV AND SUBQ ORDERS
P: 800-648-8055 | F: 414-563-0600

PATIENT INFORMATION
Fax completed form, insurance information and clinical documentation to 414-563-0600

Patient Name: ______________________ DOB: __________ Phone: ______________

Patient Status: ❒ New to Therapy ❒ Continuing Therapy **Date of last infusion:** ______________________

MEDICAL INFORMATION
ICD-10 Code (required): __________________ **ICD-10 descriptions:** ______________________

Patient weight: __________ kg Height: __________ Diabetic: ❒ Yes ❒ No If obese, use adjusted body wt? ❒ Yes ❒ No

Allergies: ______________________ Brand previously used: ______________________

THERAPY ORDER
❒ **IV** ❒ **SQ** **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 vial size for subQ doses.

Premedication orders: *to be administered 15-30 minutes before infusion*

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

Lab orders: ______________________ **Lab frequency:** ❒ Each infusion ❒ Other: __________

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen® 0.3mg or compounded syringe IM or SQ; may repeat in 5-10 minutes x 1
  - 15-30kg (33-66lbs): EpiPen® 0.15mg or compounded syringe IM or SQ; 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 ASCENSION AT HOME TOGETHER WITH COMPASSUS 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 Ascension at Home together with Compassus 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 AAH together with Compassus selecting Site of care (if checked, please list site of care) ______________

PREFERRED LOCATION
City: ______________________ State: __________

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COMPREHENSIVE SUPPORT FOR IMMUNOGLOBULIN THERAPIES
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REQUIRED DOCUMENTATION FOR INSURANCE APPROVAL
GENERAL REQUIREMENTS

- Patient demographics
- Insurance information
- All applicable diagnoses
- History and physical
- 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

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