COMPASSUS®

IMMUNOGLOBULIN (IG) IV AND SUBQ ORDERS
P: 888-386-0886 | F: 586-263-3306

PATIENT INFORMATION

Fax completed form, insurance information and clinical documentation to 586-263-3306

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 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 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 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