Agile Infusion Services LLC
Web: www.AgileIV.com | Tel: (201) 751-2202 | Fax: (201) 266-0437 | Email: info@AgileIV.com

GAMMAKED MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ DOB _____

Patient's height in feet and inches _____ *Patient's weight in pounds* _____

■ Diagnosis
Please provide the diagnosis **and** the most specific ICD-10 code available: _____

■ Details Needed for Approval
- Recent laboratory results including patient's IgG levels. Other disease-specific labs should be included (eg. platelet count with ITP).
- Chart should include history of difficult-to-treat infections, deficiency in producing antibodies in response to vaccination, etc.

■ Premedication Order
Oral medications to be taken by the patient at least 60 minutes prior to start of infusion treatment. May be taken at home:
☐ Acetaminophen _____mg ☐ Diphenhydramine _____mg ☐ Cetirizine _____mg

IV medications to be administered prior to start of the infusion treatment (for infusions only, not for injections):
☐ Dexamethosone _____mg ☐ Famotidine _____mg ☐ Methylprednisolone _____mg
☐ Diphenhydramine _____mg ☐ Metoclopramide _____mg ☐ _____

■ Medication Order
☐ Gammaked
☐ Please check here only if we may not substitute Gammaked for another IVIG brand, depending on brand availability and allocation limitations.

Dose: _____ mg/kg *If treatment is split over a few visits, list the dose per visit. So if it is 2,000mg/kg total over 4 infusions, it should be listed as 500 mg/kg here.*

Frequency: To be administered _____ for _____. (Example: 4 consecutive days per month, for 1 year)

Rate:
☐ _____ ml over _____ minutes
☐ Start at _____ ml/hr, after _____ minutes increase to _____ ml/hr, after _____ minutes increase to _____ ml/hr, after _____ minutes increase to _____ ml/hr, after _____ minutes increase to _____ ml/hr.

Volume:
☐ _____ ml of normal saline ☐ _____ ml of half normal saline ☐ _____ ml of D5W

After the infusion is complete, flush with normal saline. Check vitals and monitor for signs and symptoms of an infusion reaction at start, throughout infusion, and after completion.

■ Rescue Management in case of Infusion Therapy Reaction
Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction. Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed. For severe reactions, administer Epi-pen or equivalent and call 911.

■ Ordering Provider Authorization

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

Documentation to Include:
- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.