



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

# GAMMAPLEX 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

- Gammaplex by IV
- Please check here only if we may not substitute Gammaplex 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.**