AYSA
THERAPEUTICS INFUSION

IMMUNOGLOBULIN (IG) IV AND SUBQ ORDERS

P: 470.395.6076 **| F:** 470.745.0716

PATIENT INFORMATION:
Fax completed form, insurance information, and clinical documentation to 470.745.0716

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

INSURANCE INFORMATION:
Please attach a copy of insurance cards (front and back)

MEDICAL INFORMATION

ICD-10 Code (required): _____ ICD-10 description: _____

Patient Weight: _____ lbs. (required) Height: _____ Diabetic ☐ Yes ☐ No

Allergies: _____

First Dose: ☐ Yes ☐ No Date of Last Infusion: _____ Brand Used: _____

Lab Orders: _____

Labs: Required labs to be drawn by ☐ At Your Service Anesthesia ☐ Referring Provider

THERAPY ORDER

Ig Orders: ☐ IV ☐ Sub Q ____ gm/kg IV divided over ____ day(s) **OR** ____ mg/kg IV divided over ____ day(s)

Frequency: ☐ Repeat dose every _____ weeks for 1 year
☐ Repeat dose every _____ weeks for _____ weeks total

- Pharmacist to identify clinically appropiate Ig brand and infusion rates. May substitute based on product availability.
- 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.

Pre-Medication Orders: *to be administered 15-30 minutes before infusion*

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

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen® 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x 1
  - 15-30kg (33-66lbs): EpiPen® 0.15mg or compounded syringe IM or subQ; 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

*FOR AYSA USE ONLY

Drug/Brand Selection: _____ Date: _____

NP/Pharmacist Name: NP/Pharmacist Signature:

PROVIDER INFORMATION
Orders are good for one year from the signature date

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc.* 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: _____

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COMPREHENSIVE SUPPORT FOR IMMUNOGLOBULIN THERAPIES

REQUIRED DOCUMENTATION FOR INSURANCE APPROVAL
GENERAL REQUIREMENTS

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