Zarina Pharmacy
SPECIALTY & INFUSION

Skip this form & e-prescribe! Select BioPlus from your EHR

Fax: 832-886-4298
Phone: 832-886-4296
zarinapharmacy.com

SCIG

Ship To/Site of Care: ☐ **In Office** ☐ **Infusion Suite** ☐ **At Home** ☐ **Other:** _____

PATIENT INFORMATION

Name:		SSN:		DOB:
Address:		City:	State:	ZIP:
Home Phone:	Cell:	Height:	Weight:	Gender: ◯ Female ◯ Male
Email:				

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy#:	Group#:

CLINICAL INFORMATION

Diagnosis (ICD-10): _____ Date of Diagnosis: _____

Common Variable Immune Deficiency (CVID) Other CVID (Part B) D83.9 or D83.8 Combined Immune Deficiency D81.9 Severe Combined Immune Deficiency D81.1, D81.2
Hypogammaglobulinemia D80.1 Other Combined Immune Deficiencies D81.89 Immune-mediated Thrombocytopenia Purpura (ITP) D69.3
Kawasaki Disease M30.3 Wiskcott-Aldrich Syndrome D82.0

Has patient received immune globulin previously? ☐ No ☐ Yes: Date of last infusion _____ Date of next infusion: _____

Comorbidities: _____

Allergies: ☐ NKDA ☐ Other _____

PRESCRIPTION INFORMATION (or attach a copy of prescription)

Subcutaneous IG Therapy:

Preferred brand _____ **OR**

☐ Pharmacist will determine appropriate product based on clinical assessment, insurance requirements, and availability.

☐ Refills: _____ times (as allowed by state or payer requirements)

Directions:

☐ Administration Rate = Follow Manufacturer's Guidelines

☐ Administer _____ mg per kg (+ or - 10%)

☐ Administer _____ grams every _____ days

Other Medication:

☐ **Acetaminophen** 650 mg tablet ☐ Premedication: 30 min before infusion PO

☐ Post-infusion every 4-6 hours, as needed for fever/headache

☐ **Diphenhydramine** 25 mg capsule ☐ Premedication: 30 min before infusion PO

☐ Post-infusion every 4-6 hours ,as needed for itching/site reactions

☐ **Lidocaine** 2.5% and Prilocaine 2.5% cream 30 g. Apply small amount topically to insertion site(s) prior to needle insertion, as needed.

☐ Other: _____ Strength: _____

Directions: _____

☐ Other: _____ Strength: _____

Directions: _____

Anaphylaxis Kit Order (Infusion Reaction Management x1/year)

STOP INFUSION IMMEDIATELY.

Administer reaction management medications.

- Acetaminophen (Tylenol) 500 mg PO every 4 hours PRN myalgia or fever > 101.3
- Diphenhydramine (Benadryl) 25 mg IV every 4 hours PRN urticarial, pruritus, or shortness of breath.
- If symptoms are rapidly progressing or continue after the diphenhydramine: give epinephrine (1:1000 strength) 0.3 mL SUBQ. May repeat every 10-15 mins.

Notify Physician immediately for any new onset of the following life threatening hypersensitivty reactions to include fever, chills, dyspnea, pruritus, urticarial, convulsions, erythematous rash, hypotension, back pain, sudden chest pain, or hypertension. Call 911 as appropriate.

☐ **Diphenhydramine 50 mg/1 mL**

IM/ IV Dose: Adult = 10-50 mg per dose every 24 hours to a maximum of 400 hours. Administer as an IV push over 5 minutes.

☐ **Epinephrine 1:1000 (1 mg/1 mL)**

SUBQ Dose: Adult = 0.2-0.5 mL per dose every 15-30 minutes for 3-4 doses or every 4 hours as needed.

NURSING

☐ **Nursing Agency:** _____ **Phone:** _____

Skilled Nursing Visits for infliximab intravenous administration and education. To provide education related to the disease process and therapy. To provide an assessment of patient's general overall health status. To provide skilled nursing visits PRN for additional education and support.

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution.	☐ Dispense as written

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:	
Office Contact:		Email:	
Address:	City:	State:	ZIP:
NPI #:		Tax ID:	
Prescriber Signature:		Date:	