McLeod Health

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Immune Globulin (Gamunex-C) Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Diagnosis (select one and complete the 2nd and 3rd digits to complete the ICD-10 code):

☐ D80.__ Hypogammaglobulinemia/Select IG Deficiency ☐ D83.___ Common variable immune deficiency

☐ G61.81 CIDP ☐ G61.0 Guillain-Barre syndrome

☐ M33.9__ Dermatopolymyositis ☐ D69.3 ITP

☐ M33.2__ Polymyositis ☐ G70.___ Myasthenia Gravis

☐ Other: ICD 10 Code: _____ Diagnosis Description: _____

Pre-Medications: **administered 30 minutes prior to infusion**

☐ None

☐ Acetaminophen 650 mg PO

☐ Diphenhydramine: Dose: ☐ 25 mg ☐ 50 mg Route: ☐ PO or ☐ IVP

☐ Methylprednisolone: Dose: ☐ 40 mg or ☐ 125 mg Route: IVP

☐ Famotidine: Dose: 20 mg Route: ☐ PO or ☐ IVPB

☐ Other (include drug, dose, and route): _____

Drug Orders:

• IVIG (Gamunex-C) (J1561) infused IV via titration protocol unless otherwise specified

● Dose (Based on Actual BW): □ _____ gm/kg/day □ _____ g/day

• Frequency: ☐ Once □ Daily x ____ doses □ Once every _____ weeks

☐ Other: _____

• Order Duration: Six months unless otherwise specified (Other: _____)

Lab Orders:

☐ _____

Standing Orders:

• Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Pre-Screening Requirements:

□ Provide IgG level (for immunodeficiency patients only) prior to start of therapy

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received any IVIG product at another facility, please provide last date received: _____

Insurance/Authorization Information:

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Clarendon: 803-435-3194 (Fax)

803-435-3226 (Phone)