

McLeod Health

Immune Globulin (Gamunex-C) Treatment Plan

Patient Name: _____ DOB: _____

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

Patient Primary Phone Number: _____

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

- | | |
|---|---|
| <input type="checkbox"/> D80.____ Hypogammaglobulinemia/Select IG Deficiency | <input type="checkbox"/> D83.____ Common variable immune deficiency |
| <input type="checkbox"/> G61.81 CIDP | <input type="checkbox"/> G61.0 Guillain-Barre syndrome |
| <input type="checkbox"/> M33.9__ Dermatopolymyositis | <input type="checkbox"/> D69.3 ITP |
| <input type="checkbox"/> M33.2__ Polymyositis | <input type="checkbox"/> G70.____ Myasthenia Gravis |
| <input type="checkbox"/> 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: One year 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.
- Appropriate access and line care orders per health system policy

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 Information:

Insurance Plan Name: _____

Insurance Identification Number: _____

Insurance Customer Service Contact Number: _____

Preferred Treatment Location

- | | | |
|--|---|--|
| <input type="checkbox"/> McLeod Regional Medical Center (Florence) | <input type="checkbox"/> McLeod Health Loris | <input type="checkbox"/> McLeod Health Cheraw |
| <input type="checkbox"/> McLeod Health Seacoast (Little River) | <input type="checkbox"/> McLeod Health Dillon | <input type="checkbox"/> McLeod Health Clarendon (Manning) |

Fax completed Treatment Plan to the McLeod Medication Access Team at 843-777-9798. For any questions, please contact our team at medicationaccessteam@mcleodhealth.org.