McLeod Health

Immune Globulin (Gamunex-C) Treatment Plan

Patient Name:	DOB:	
Height (cm): Weight (kg):		
Patient Primary Phone Number:		
Diagnosis (select one and complete the 2 nd and 3 rd 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 De	escription:	
<u>Pre-Medications:</u> **administered 30 minutes prior to infu	ısion**	
□ None		
☐ Acetaminophen 650 mg PO		
☐ Diphenhydramine: Dose: ☐ 25 mg ☐ 50 mg R	oute: PO or IVP	
☐ Methylprednisolone: Dose: ☐ 40 mg or ☐ 125 mg R	oute: IVP	
☐ Famotidine: Dose: 20 mg R	oute: PO or IVPB	
☐ Other (include drug, dose, and route):		
Drug Orders:		
• IVIG (Gamunex-C) (J1561) infused IV via titration protoco	ol 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 (0		
Lab Orders:		
Standing Orders:		
• Infusion Reaction Protocol (CPOE-1396) will be activated Infusion will be stopped and physician notified.	I if any hypersensitivity reaction occurs, including anap	
Physician Signature:	Date:	
Physician Name:	Phone:	

Pre-Screening Requirements:			
☐ Provide IgG level (for immunodeficiency pation	ents only) prior to start of the	erapy	
Previous Therapies:			
• For new patient referrals, please send history	and physical and most recen	t physician note with completed p	olan
If patient has previously received any IVIG pro	oduct at another facility, plea	se provide last date received:	
Insurance Information:			
Insurance Plan Name:			
Insurance Identification Number:			
Insurance Customer Service Contact Number: _			
Preferred Treatment Location			
☐ McLeod Regional Medical Center (Florence)	☐ McLeod Health Loris	☐ McLeod Health Cheraw	
☐ McLeod Health Seacoast (Little River)	☐ McLeod Health Dillon	☐ 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.