☐ *Borough Park*
1428 36th Street
Suite 107
Brooklyn, NY 11218

☐ *Crown Heights*
555 Lefferts Avenue
Brooklyn, NY 11225

☐ *Manhattan*
57W 57Street
Suite 601
New York, NY 10019

☐ *Manhasset*
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ *Rockville Centre*
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

☐ *Elmsford/ Terrytown*
555 Taxter Road
3rd Floor
Elmsford, NY 10523

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

☐ *Manhattan*
225 E 70th Street
Suite 1E
New York, NY 10021

☐ *Queens*
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ *Manhattan*
225 East 70th Street
New York, NY 10021

☐ *Holbrook/ Ronkonkoma*
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ *Scarsdale*
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

☐ *5 Towns*
141 Washington Avenue
Cedarhurst, NY 11559

☐ *Riverhead*
1228 E Main Street
Suite A
Riverhead, NY 11901

(intravenous immunoglobulin)

IVIG infusion order

Date: _____

Gamunex (10%), Gammagard (10%), Gammaked, Gammaplex 10%), Panzyga (10%), Privigen (10%), Octagam

Patient Name _____ DOB _____

Phone _____ M ◯ F ◯

◯ Allergies _____

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

Insurance Carrier (secondary) _____

REFERRAL STATUS

☐ New Prescription
☐ Order Renewal
☐ Does or Frequency Change
☐ Discontinuation

*DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Primary Immunodeficiency (PI)
☐ _____ Idiopathic Thrombocytopenic Purpura (ITP)
☐ _____ Multifocal Motor Neuropathy (MMN)
☐ _____ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
☐ _____ Myasthenia Gravis
☐ _____ Hypogammaglobulinemia
☐ _____ _____ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ _____ *(other)*
☐ Solu-Medrol 125mg IVP
☐ Diphenhydramine 25mg IVP
☐ Solu-Cortef 100mg IVP
☐ _____ *(other)*

IVIG ORDERS

BRAND

◯ Gamunex (10%) ◯ Privigen (10%) ◯ Octagam (10%) ◯ Gammaplex (10%)
◯ Gammagard (10%) ◯ Panzyga (10%) ◯ Gammaked (10%) ◯ IV _____

DOSAGE

◯ _____ gm per day
◯ _____ mg/kg over
◯ Other_____

X ____ days

FREQUENCY

◯ every _____ weeks
◯ one-time dose/treatment
◯ Other_____

PATIENT WEIGHT

_____ lbs.
_____ kg

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____