

(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) _____

REFERRAL STATUS

Insurance Carrier (secondary) _____

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

*DIAGNOSIS Please provide ICD-10 code

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

PRE-MEDICATION

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

IVIG ORDERS

BRAND

- | | | | |
|---------------------------------------|--------------------------------------|--------------------------------------|---------------------------------------|
| ☐ Gamunex (10%) | ☐ Privigen (10%) | ☐ Octagam (10%) | ☐ Gammaplex (10%) |
| ☐ Gammagard (10%) | ☐ Panzyga (10%) | ☐ Gammaked (10%) | ☐ IV _____ |

DOSAGE

- ☐ _____ gm per day X _____ days
- ☐ _____ mg/kg over _____ days
- ☐ Other _____

FREQUENCY

- ☐ every _____ weeks
- ☐ one-time dose/treatment
- ☐ Other _____

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____