

Los Angeles, CA
2080 Century Park East
Suite 710
Los Angeles, CA 90067



(intravenous immunoglobulin)

IVIG

Infusion orders

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

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 Solu-Medrol 125mg IVP
 Diphenhydramine 25mg PO Solu-Cortef 100mg IVP
 Cetirizine 10mg PO Diphenhydramine 25mg IVP

_____ (other) _____ (other)

IVIG ORDERS

BRAND:

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

PATIENT WEIGHT

_____ lbs.
_____ kg

DOSAGE:

• _____ gm per day • x _____ days
 • _____ mg/kg over

Other _____

Frequency:

every _____ weeks
 one-time dose/treatment
 Other _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____