Boca Raton
9980 Central Park Blvd
Suite 202, N
Boca Raton, FL 33428

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

(intravenous immunoglobulin)

IVIG
Iinfusion orders

Date: ____________________

PATIENT INFORMATION		
Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS				
☐New Referral	☐Referral Renewal	☐Medication/Order Change	☐Benefits Verification Only	☐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
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO

________________________ *(other)*

- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP

________________________ *(other)*

IVIG ORDERS

BRAND:

- ☐ Gamunex (10%)
- ☐ Gammagard (10%)
- ☐ Privigen (10%)
- ☐ Panzyga (10%)
- ☐ Octagam (10%)
- ☐ Gammaked (10%)
- ☐ Gammaplex (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 ______________