

(intravenous immunoglobulin)

IVIG

Infusion 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:

IVIG ORDERS

BRAND:

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

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)

PATIENT WEIGHT

_____ lbs.

_____ kg

DOSAGE: Grams/Day

- ☐ _____ gm per day ☐ ONCE
☐ _____ gm per day DAILY x _____ days

Frequency:

- ☐ ONCE
☐ Every _____ weeks x _____ weeks
☐ for 1 year
☐ Other _____

DOSAGE: Grams/Day

- ☐ _____ mg/kg over ☐ _____ days

Frequency:

- ☐ ONCE
☐ Every _____ weeks x _____ weeks
☐ for 1 year
☐ Other _____

NOTES/ADDITIONAL COMMENTS:

REQUIRED DOCUMENTATION CHECKLIST:

- ☐ _____ Patient Demographics
☐ _____ Insurance Card/Information
☐ _____ Recent Labs
☐ _____ Recent Progress

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Diagnosis Code: _____

Order/dosage: _____

Signature: _____