

(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
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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

- | | |
|---|-------------------------------------|
| ☐ _____ gm/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: _____