

Pensacola
41 Fairpoint Drive
Suite B
Gulf Breeze, FL 32561

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



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: _____

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

If the medication selected above is not covered or is non-preferred by the patient's insurance, the prescribing provider authorizes consideration of the clinically appropriate alternatives listed below. Final medication selection will be based on provider clinical judgment and/or payer requirements. Provider signature below confirms authorization for the above substitution(s), if applicable.

IVIG BIOSIMILARS:

- Gamunex
 Gammagard
 Privigen
 Panzyga
 Octagam
 Gammaked
 Gammaplex
 Asceniv

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Diagnosis Code: _____
Order/dosage: _____
Signature: _____