

Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Forest Hills
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

Sheepshead Bay
2546 East 17th Street
Fl. 1
Brooklyn, NY 11235

Long Island City
36-36 33rd
Suite 311
Long Island City, NY 11106

Bronx
226 West 238th Street
Bronx, NY 10463

Massapequa
97 Grand Avenue
Massapequa, NY 11758

E 56th & Park Midtown
120 East 56 Street
Suite 300
New York, NY 10022

FIDI
30 Broad Street
Suite 401
New York, NY 10004

Gramercy
7 Gramercy Park West
Lower Level
New York, NY, 10003

NYC
E 70th St Upper East Side
225 E 70th Street
Suite 1E
New York, NY 10021

Central Park West
115 Central Park West
Suite 15
New York, NY 10023



Tarrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Port Jefferson
12 Medical Drive
Suite B
Port Jefferson Station, NY 11776

Staten Island
27 New Dorp Lane
Staten Island, NY 10306

Southampton
625 Hampton Road
Southampton, NY 11968

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Holbrook
233 Union Avenue
Suite 207
Holbrook, NY 11741

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Rockville Centre
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

New Hyde Park
1991 Marcus Ave
Suite 110
Lake Success, NY, 11042

Woodbury
7600 Jericho Tpke,
Lower Level, Suite C500
Woodbury NY 11797

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

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:

- | | |
|--|--|
| <input type="checkbox"/> Gamunex (10%) | <input type="checkbox"/> Octagam (10%) |
| <input type="checkbox"/> Gammagard (10%) | <input type="checkbox"/> Gammaked (10%) |
| <input type="checkbox"/> Privigen (10%) | <input type="checkbox"/> Gammaplex (10%) |
| <input type="checkbox"/> Panzyga (10%) | <input type="checkbox"/> 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

- | | |
|--|---|
| <input type="checkbox"/> Tylenol 1000mg PO | <input type="checkbox"/> Solu-Medrol 125mg IVP |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Solu-Cortef 100mg IVP |
| <input type="checkbox"/> Cetirizine 10mg PO | <input type="checkbox"/> 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: _____