

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:	
<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"/> Gammplex (10%)
<input type="checkbox"/> Panzyga (10%)	<input type="checkbox"/> IV _____
DIAGNOSIS <i>Please provide ICD-10 code</i>	
<input type="checkbox"/> _____ Primary Immunodeficiency (PI)	
<input type="checkbox"/> _____ Idiopathic Thrombocytopenic Purpura (ITP)	
<input type="checkbox"/> _____ Multifocal Motor Neuropathy (MMN)	
<input type="checkbox"/> _____ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	
<input type="checkbox"/> _____ Myasthenia Gravis	
<input type="checkbox"/> _____ 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)	

PATIENT WEIGHT	
_____ lbs.	
_____ kg	
DOSAGE: Grams/Day	
<input type="checkbox"/> _____ gm per day	<input type="checkbox"/> ONCE
<input type="checkbox"/> _____ gm per day DAILY	x _____ days
Frequency:	
<input type="checkbox"/> ONCE	
<input type="checkbox"/> Every _____ weeks x _____ weeks	
<input type="checkbox"/> for 1 year	
<input type="checkbox"/> Other _____	
DOSAGE: Grams/Day	
<input type="checkbox"/> _____ gm/kg over	<input type="checkbox"/> _____ days
Frequency:	
<input type="checkbox"/> ONCE	
<input type="checkbox"/> Every _____ weeks x _____ weeks	
<input type="checkbox"/> for 1 year	
<input type="checkbox"/> Other _____	

NOTES/ADDITIONAL COMMENTS:

REQUIRED DOCUMENTATION CHECKLIST:
<input type="checkbox"/> _____ Patient Demographics
<input type="checkbox"/> _____ Insurance Card/Information
<input type="checkbox"/> _____ Recent Labs
<input type="checkbox"/> _____ 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 Gammplex Asceniv

ORDERING PROVIDER

Signature **X** _____ Date _____
 Provider _____ Phone _____ Fax _____

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