Vermont
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Suite #1A
Williston, VT 05495

ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

IVIG
Iinfusion 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%)
- ☐ Gammagard (10%)
- ☐ Privigen (10%)
- ☐ Panzyga (10%)
- ☐ Octagam (10%)
- ☐ Gammaked (10%)
- ☐ Gammaplex (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
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ 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: _____