Intravenous Immune Globulin (IVIG)

Provider Order Form

PATIENT INFORMATION

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Address: City: State: Zip Code:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

☐ NKDA ☐ Allergies: Weight lbs/kg: Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change Last infusion date (if applicable):

REQUIRED DOCUMENTATION

☐ Labs (IgG) ☐ Insurance Card (front and back) ☐ Current Medications ☐ History/Progress Notes

ICD-10 CODE

☐ D69.3 Idiopathic thrombocytopenia purpura (ITP)
☐ D80.9 Primary humoral immunodeficiency (PI)
☐ D82.0 Wiskott-Aldrich syndrome
☐ M33.13 Dermatomyositis without myopathy
☐ G61.81 Chronic inflammatory demyelinating polyneuropathy (CIDP)
☐ D83.9 Common variable immunodeficiency/agammaglobulinemia
☐ G61.82 Multifocal motor neuropathy
☐ Other:_____

PRE-MEDICATION ORDER

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO

Cetirizine (Zyrtec) ☐ 10mg PO

Loratadine (Claritin) ☐ 10mg PO

Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

Methylprednisolone (Solu-Medrol) ☐ 40mg IV ☐ 125mg IV

Hydrocortisone (Solu-Cortef) ☐ 100mg IV

Other: _____ Dose:_____ Route:_____ Frequency: _____

MEDICATION ORDER

No brand preference. Health Infusion Services will select IVIG product based on availability

☐ Brand preference: _____

Dose and frequency:

☐ _____ gm/kg or _____ grams IV divided over _____ days every _____ weeks

☐ _____ grams IV every _____ weeks

☐ _____ mg/kg IV every _____ weeks

☐ Other: _____

PROVIDER INFORMATION

Provider Name: Provider Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

SPECIAL INSTRUCTIONS

Provider Name **Provider Signature** **Date** ☐ **Check here if this is a stat order**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

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