Intravenous Immunoglobulin (IVIG)

Provider Order Form rev. 01/02/2024

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Primary Humoral Immunodeficiency: Idiopathic thrombocytopenia Purpura:

Chronic Inflammatory Demyelinating Polyneuropathy: Multifocal Motor Neuropathy:

Other: Dermatomyositis:

THERAPY ADMINISTRATION *(Select one)*

☐ Gamunex C ☐ Gammagard Liq. ☐ Privigen
☐ Octagam 5% ☐ Octagam 10% ☐ Panzyga
☐ Asceniv *(Please note, to be covered for this therapy, pt must have failed multiple preferred products)*

DOSING

Loading: _____ g/kg=_____(dose) IV over _____ Day(s)
Maintenance: _____ g/kg_____(dose) IV over _____ Day(s)
☐ Brand name checked above medically necessary

MAINTENANCE DOSE FREQUENCY *(Choose one)*

☐ Every _____ weeks
☐ Every _____ months
☐ Once
☐ Other: _____

ADDITIONAL ORDERS

☐ Ok to leave IV to saline lock for tx on consecutive days

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO
☐ Loratadine 10mg PO
☐ Pepcid 20mg ☐ PO / ☐ IVP
☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP
☐ Solumedrol ☐ 40mg / ☐ 125mg IVP
☐ Other: _____

NURSING

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation
☑ Monitor vital signs every 30 minutes and with each rate change.
☑ Administration guidelines vary by IVIG product and brand. Review manufacturer instructions for infusion rate, titration schedule, and filtration requirements.

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications.
Required Labs: Immunoglobulin levels, Renal function, CRP/ESR, ANA,

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.