

# Intravenous Immunoglobulin (IVIG)

Provider Order Form rev. 12/30/2025

## 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)

Infuse IVIG product based on payer requirements, indication, or product availability. (Alyglo, Asceniv, Gamunex-C, Gammagard Liq., Octagam 10%, Panzyga, Privigen)  
 Infuse this branded IVIG product (subject to prior authorization): \_\_\_\_\_

## DOSING

Loading: \_\_\_\_\_ g/kg= \_\_\_\_\_ (dose) IV over \_\_\_\_\_ Day(s)

Maintenance: \_\_\_\_\_ g/kg= \_\_\_\_\_ (dose) IV over \_\_\_\_\_ Day(s)

## MAINTENANCE DOSE FREQUENCY (Choose one)

Every \_\_\_\_\_ weeks

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 per policy

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.