Intravenous Immunoglobulin (IVIG)

Provider Order Form rev. МН/ОЛ/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 1 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.