Patient Name:______________________________

DOB:________ Wt(kg) & date collected:____________

Allergies:_______________Phone:________________

IV Immune Globulin Infusion Orders

Required Information:

Signed order from prescribing provider

Patient demographics including insurance information

Supporting clinical documentation: Visit notes, lab & imaging results

Past IG treatment history

Primary Diagnosis:

___________________(ICD-10:___________)

Secondary Diagnosis:

___________________(ICD-10:_____________)

ORDERS

Product:

Gammagard   Gammaked   Gamunex -C

Octagam   Panzyga   Privigen

Other:_____________________   5%   10%

Dose:

_______ mg/kg IV divided over _____ day(s)

_______ gm IV divided over _____ day(s)

Other:________________________

Frequency:

Once every _____ weeks

Once every _____ days

Other:________________

Duration:

1 year

or

___ # of treatments

History:

Date of last IVIG:__________

Product:___________

Infusion Rates:

Per manufacturer guidelines

Other:____

____

____

PRE-MEDICATIONS

Tylenol _______mg PO

Cetirizine _______mg PO

Loratadine _______mg PO

Diphenhydramine ______mg PO or IV

Solu-Medrol _______mg IVP

Other:_________ _____mg PO or IV

LABS

CBC   IG Panel

CMP   ESR

CRP   Other:__________

Frequency: Every Infusion

Every 6 months

Other:________

CPL Acct #:_____________

ADDITIONAL INSTUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

____

____

____

Physician Name:	**Phone:**	**Fax:**
Physician Signature:	**NPI:**	**Date:**