IVIG
INFUSION ORDERS

****REQUIRED INFORMATION****

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ Clinical/Progress Notes, Labs & Tests supporting primary diagnosis (ICD-10 below)

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis:_____ (ICD-10:_____)

Patient Weight _____ kg

☐ Gammagard (J1569) ☐ Gammaplex (J1557) ☐ Gamunex C (J1561) ☐ Privigen (J1459)	☐ Carimune_____% (J1566) ☐ Flebogamma (J572) ☐ Bivigam (J1556) 5% ☐ Bivigam (J1556) 10%

IVIG Orders: _____mg/kg IV divided over _____day(s)
_____mg/kg IV divided over _____day(s)
Frequency: Every_____weeks or _____one time dose
Protocol Pre-Medication Orders:

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO

Additional Pre-Medication Orders:

- ☐ Additional Pre-Medication Orders: Solu-Medrol _____ mg IVP

NS 0.9% _____ mL IV

Additional Instructions:

Physician Name:	Phone:	Fax:
Physician signature:	Date:	