



Nucara Pharmacy Nucara Infusion Center
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Austin, TX 78757 Austin, TX 78757
Phone: 512-454-9923 Phone: 512-454-9923 x8
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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 Solu-Medrol _____mg IVP
Cetirizine _____mg PO Other: _____mg PO or IV
Loratadine _____mg PO
Diphenhydramine _____mg
PO or IV

LABS

CBC IG Panel Frequency: Every Infusion
CMP ESR Every 6 months
CRP Other: _____
CPL Acct #: _____

ADDITIONAL INSTRUCTIONS

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

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