

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: _____)

Pt. Weight _____ kg Allergies: _____

IVIG ORDERS

- | | |
|--|---|
| <input type="checkbox"/> Gammagard (J1569)
<input type="checkbox"/> Gammaplex (J1557)
<input type="checkbox"/> Gamunex C (J1561)
<input type="checkbox"/> Bivigam (J1556) | <input type="checkbox"/> Privigen (J1459)
<input type="checkbox"/> Carimune _____% (J1566)
<input type="checkbox"/> Flebogamma (J572)
<input type="checkbox"/> 5% <input type="checkbox"/> 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, *please choose one antihistamine:*

- Cetirizine 10mg PO
- Diphenhydramine 25mg PO
- Loratadine 10mg PO

Additional Pre-Medication Orders: Solu-Medrol _____ mg IVP
 NS 0.9% _____ mL IV

Additional Instructions:

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