Local Infusion

MYLOCALINFUSION.COM

IVIG ORDER FORM

Local Infusion will select the product based on payor requirements, product availability and indication:
Bivigam Gammagard Liquid 10% Gammaked 10% Gamunex-C 10%
Octagam 5% Octagam 10% Privigen Panzyga

❑ **DO NOT SUBSTITUTE. Administer brand:** _____

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____

Allergies: _____

DIAGNOSIS (Provider must specify)

❑ Chronic Inflammatory Demyelinating Polyneuropathy, ICD 10: _____
❑ Primary Immunodeficiency, ICD 10: _____
❑ Myasthenia Gravis, ICD 10:._____
❑ Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO
❑ Benadryl 25mg PO
❑ Famotidine 20 mg IV
❑ Cetirizine (Zyrtec) 10 mg PO
❑ Methylprednisolone (Solu-Medrol) 125 mg IVP
❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE*	ROUTE	FREQUENCY
IVIG	❑ _____ GRAMS/kg ❑ _____ GRAMS *Dose will be rounded up to nearest vial size.	❑ IV ❑ Administer as single day infusion ❑ Divide dose over _____ days	❑ Once ❑ Every ____ weeks ❑ Every ____ months

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❒ CT: 203.433.0621 ❒ MD: 240.224.8607 ❒ ME: 207.407.7272 ❒ NH: 603.217.5371
❒ NJ: 201.581.4521 ❒ VA: 703.202.0499

Order valid for 1 year from date of signature unless otherwise specified here: _____