Local Infusion

MYLOCALINFUSION.COM

IVIG ORDER FORM

❑ Asceniv ❑ Bivigam ❑ Gammagard Liquid 10% ❑ Gamunex-C 10% ❑ Gammaplex 5% ❑ Gammaplex 10%
❑ Octagam 5% ❑ Octagam 10% ❑ Privigen ❑ Panzyga ❑ Qivigy

❑ **Dispense As Written (DAW)**
Will substitute for biosimilar or reference product based on insurance and availability

PATIENT INFORMATION

Patient Name: _____ DOB: _____
Mobile Number: _____ Patient Weight: _____kg
Allergies: _____
❑ Patient has known difficult venous access. Comments: _____
❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

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

❑ IV ❑ SubQ Local Infusion will identify clinical appropriateness related to brand and infusion rates. May substitute based on the patient's insurance and product availability.
All IVIG doses will be rounded to the nearest increment ending in 0 or 5 (e.g., 25 g, 30 g, 35 g) in accordance with institutional dosing guidelines.

Loading Dose (as applicable)	_____	❑ mg/kg ❑ gm/kg ❑ grams	x _____ day(s) OR divided over _____ days(s)	❑ One time dose ❑ Other: _____ *Give maintenance dose _____ days after loading dose*
Maintenance Dose	_____	❑ mg/kg ❑ gm/kg ❑ grams	x _____ day(s) OR divided over _____ days(s)	❑ Every _____ weeks x 1 year ❑ Other: _____

LABS / SPECIAL INSTRUCTIONS

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

FAX NUMBERS:
❑ CT: 203.433.0621
❑ FL: 904.877.9270
❑ MA: 413.296.8482
❑ MD: 240.224.8607
❑ ME: 207.407.7272
❑ NC: 919.984.8698
❑ NH: 603.217.5371
❑ NJ: 201.581.4521
❑ NY: 631.250.6020
❑ OH: 937.871.4594
❑ PA: 610.273.5998
❑ SC: 864.973.6279
❑ VA: 703.202.0499