

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: _____

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

MEDICATION

- IV
 SubQ Active infusions will identify clinically appropriate brand/infusion rates. May substitute based on 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)	_____	<input type="checkbox"/> mg/kg <input type="checkbox"/> gm/kg <input type="checkbox"/> grams	x _____ day(s) OR divided over _____ days(s)	<input type="checkbox"/> One time dose <input type="checkbox"/> Other: _____ Give maintenance dose _____ days after loading dose
Maintenance Dose	_____	<input type="checkbox"/> mg/kg <input type="checkbox"/> gm/kg <input type="checkbox"/> grams	x _____ day(s) OR divided over _____ days(s)	<input type="checkbox"/> Every _____ weeks x 1 year <input type="checkbox"/> Other: _____

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

LABS / SPECIAL INSTRUCTIONS

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

FAX NUMBERS:

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> CT: 203.433.0621 | <input type="checkbox"/> MA: 413.296.8482 | <input type="checkbox"/> NC: 919.984.8698 | <input type="checkbox"/> NY: 631.250.6020 | <input type="checkbox"/> SC: 864.973.6279 |
| <input type="checkbox"/> FL: 904.877.9270 | <input type="checkbox"/> MD: 240.224.8607 | <input type="checkbox"/> NH: 603.217.5371 | <input type="checkbox"/> OH: 937.871.4594 | <input type="checkbox"/> VA: 703.202.0499 |
| | <input type="checkbox"/> ME: 207.407.7272 | <input type="checkbox"/> NJ: 201.581.4521 | <input type="checkbox"/> PA: 610.273.5998 | |