(intravenous immunoglobulin)

IVIG infusion orders

Patient Name _____ DOB _____

Phone _____ M ◯ F ◯

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Primary Immunodeficiency (PI)
- ☐ _____ Idiopathic Thrombocytopenic Purpura
- ☐ _____ Multifocal Motor Neuropathy (MMN)
- ☐ _____ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- ☐ _____ Myasthenia Gravis
- ☐ _____ Hypogammaglobulinemia
- ☐ _____ _____ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Cetirizine 10mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ _____
- ☐ Length of Need _____
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____

IVIG ORDERS

BRAND

- ◯ Gamunex (10%)
- ◯ Gammagard (10%)
- ◯ Privigen (10%)
- ◯ Flebogamma DIF (10%)
- ◯ Octagram (10%)
- ◯ Gammaked (10%)
- ◯ Gammaplex (10%)
- ◯ Carimune ____ %

DOSAGE

- ◯ gm per day
- ◯ mg/kg over

X _____ days

FREQUENCY

- ◯ one-time does/treatment
- ◯ every _____ weeks
- ◯ Refills: _____

PATIENT WEIGHT

_____ lbs.

_____ kg

Notes

ORDERING PROVIDER

Signature **X**_____ Date _____

Provider _____ Phone_____ Fax _____

Address _____

_____

NPI# _____

DEA# _____

FAX ORDERS: 702-780-4887