

# IVIG (Intravenous Immunoglobulin 10%)

## PATIENT INFORMATION

Referral Status (check one):  New Referral  Updated Order  Order Renewal

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

NKDA  Allergies: \_\_\_\_\_ Weight \_\_\_\_\_ Please specify:  lbs  kg Height: \_\_\_\_\_

Patient Status (check one):  New to Therapy  Continuing Therapy | Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

ICD-10 code (required): \_\_\_\_\_ ICD-10 description: \_\_\_\_\_

**REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

## PRESCRIPTION

### PRE-MEDICATION ORDERS

- acetaminophen (Tylenol)  500mg |  650mg |  1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl)  25mg |  50mg |  PO |  IV
- famotidine (Pepcid) 20mg PO
- methylprednisolone (Solu-Medrol)  125mg IV
- hydrocortisone (Solu-Cortef)  100mg IV
- Other: \_\_\_\_\_
- Dose: \_\_\_\_\_ Route: \_\_\_\_\_
- Frequency: \_\_\_\_\_

### THERAPY ADMINISTRATION

Immune Globulin:  No preference  Preferred product: \_\_\_\_\_

#### Choose an Indication below.

Primary Immunodeficiency (PI) \_\_\_\_\_ mg/kg (ref range 100-800mg/kg every 3-4 weeks)

Chronic Inflammatory demyelinating polyneuropathy (CIDP) **Loading:** \_\_\_\_\_ gm/day x \_\_\_\_\_ days; OR \_\_\_\_\_ gm/kg/course divided over \_\_\_\_\_ days (ref range 2g/kg)  
**Maintenance:** \_\_\_\_\_ gm/day x \_\_\_\_\_ days; OR \_\_\_\_\_ gm/kg/course divided over \_\_\_\_\_ days (ref range 1g/kg every 3 wks)

Multifocal motor neuropathy (MMN) \_\_\_\_\_ gm/day x \_\_\_\_\_ days; OR \_\_\_\_\_ gm/kg/course divided over \_\_\_\_\_ days (ref range 0.5- 2.4gm/kg)

Idiopathic thrombocytopenia purpura (ITP) 1g/kg. Up to three separate doses may be given on alternate days

OTHER  
 \*Include dosage, frequency and any other special instructions

Flush with 5% dextrose in water (D5W) at completion of infusion  Patient required to stay for 60-min observation post infusion  
 Refills:  Zero /  for 12 months /  \_\_\_\_\_ (if not indicated order will expire one year from date signed)

## PROVIDER INFORMATION

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

\_\_\_\_\_  
 Provider Name (Print) Provider Signature Date