# IVIG 10%

**Asceniv, Gamunex-C, Gammagard, Privigen, Bivigam, Octagam, Flebogamma, Gammaplex, Panzyga**

Treatment Location: _____

**PROVIDERS: Please include the following to expedite the order:**
Patient Demographics, Most Recent Office Visit Note, Insurance Information

## PATIENT INFORMATION

**Referral Status:** ☐ New Referral ☐ Updated Order ☐ Order Renewal ☐ Home Infusion

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ D80. ___ ☐ D83. ___ ☐ G61.8 ___ ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

## PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

## NURSING

☑ Center will use Hypersensitivity protocol established by Infusion for Health and PI

## PRE-MEDICATION ORDERS

***Pre-Medications not usually indicated.***

☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

## LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ IgA/IgG levels ☐ at each dose ☐ every _____

☐ Other: _____ ☐ Frequency: _____

☐ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

## THERAPY ADMINISTRATION

☑ Intravenous Immunoglobulin 10% (IVIG 10%)

**Dose:** ☐ _____ g/kg

☐ _____ mg/kg

☐ _____ grams (fixed dose)

**Route:** ☐ IV / ☐ SQ

**Frequency:** ☐ _____

**Preferred Brand:** ☐ _____

*To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.*

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

## SPECIAL INSTRUCTIONS:

Provider Name (Print) | Provider Signature | Date

☐ ***Please check this box if you DO NOT authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.***