IVIG 10%

Asceniv, Gamunex-C, Gammagard, Privigen, Bivigam, Octagam, 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.***