INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

IVIG *immune globulin intravenous*

- ☐ 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 unless DAW is checked.

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), ICD 10: _____

☐ Primary Immunodeficiency, ICD 10: _____

☐ Myasthenia Gravis, ICD 10: _____

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the 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

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

Route: ☐ IV ☐ SubQ

Infuse Care will identify clinical appropriateness related to brand and infusion rates. May substitute based on the 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.

	DOSE	UNIT	DURATION	FREQUENCY
Loading dose (as applicable)	_____	☐ mg/kg ☐ gm/kg ☐ grams	x _____ day(s) OR divided over _____ day(s)	☐ One time dose ☐ Other: _____ Give maintenance dose _____ days after loading dose
Maintenance dose	_____	☐ mg/kg ☐ gm/kg ☐ grams	x _____ day(s) OR divided over _____ day(s)	☐ Every _____ weeks x 1 year ☐ Other: _____

LABS / SPECIAL INSTRUCTIONS

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