

Intravenous Immunoglobulin 10% (IVIG 10%)

Provider Order Form rev. 1/31/23



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PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ DOB: _____
ICD-10 code (required): _____ ICD-10 description: _____
 NKDA 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 Code: _____

NURSING

Provide nursing care per 360 Infusion Center Nursing Procedures, including reaction management and post-procedure

LABORATORY ORDERS

CBC at each dose every _____
 CMP at each dose every _____
 Other: _____

PRE-MEDICATION ORDERS

acetaminophen (Tylenol) 500mg / 650mg / 1000mg PO
 cetirizine (Zyrtec) 10mg PO
 loratadine (Claritin) 10mg PO
 diphenhydramine (Benadryl) 25mg / 50mg PO / IV
 methylprednisolone (Solu-Medrol) 40mg / 125mg IV
 hydrocortisone (Solu-Cortef) 100mg IV
 Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

360 will select the product based on payor requirements, product availability, and indication: Gammagard Liquid, Gammagard SD, Gammaked, Gamunex-C, Hizentra, Octogram, Privigen, Flebogamma, Hyguia, Panzyga, Bivigam, and Cuvitru.

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 *WRITE INSTRUCTIONS HERE
*Include dosage, frequency and any other special instructions

- Flush with 5% dextrose in water (D5W) at completion of infusion
 Patient is required to stay for 30-minute observation

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

Provider Name (Print)

Provider Signature

Date