Midnight Sun ONCOLOGY

IVIG Order

Please include recent labs and last two office visit notes

Please fax to 907-746-7798 - Clinic Phone Number: 907-746-7771

PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: ☐M ☐F	Weight:
Patient Status: ☐ New to therapy ☐ Continuing therapy	Next due date (if applicable):

PHYSICIAN INFORMATION

Physician's Name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:	State:	Zip:
Office phone:	Email:	
Office contact:	Office fax:	

DIAGNOSIS INFORMATION

☐ Primary Immunodeficiency	ICD 10:	Year of Diagnosis:
☐ Other:	ICD 10:	Year of Diagnosis:

INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

Primary Insurance:	ID#	Secondary Insurance:	ID#

PRESCRIPTION INFORMATION (requires new order every 12 months)

Medication may be substituted with payer-preferred brand, generic, or biosimilar equivalent per authorization and institutional formulary

Medication: **Immune Globulin 10%**

Administer: _____Grams at _____G/kg per day over _____ days, every _____ weeks

Infusion rate will be titrated per manufacturer recommendations according diagnosis/indication and patient weight

Doses will be rounded to nearest 5 Grams

Vital signs per clinic protocol

Infusion reaction/Hydration Management per clinic protocol

PRE-MEDICATIONS: ☐ N/A

☐ Acetaminophen: ☐ 500mg ☐ 650mg ☐ 1000mg PO

☐ Loratadine (Claritin): 10mg PO

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Dexamethasone: ☐ 5mg ☐ 10mg ☐ 20 mg IV

☐ Famotidine: ☐ 20 mg IV

POST-MEDICATIONS

☐ Acetaminophen: ☐ 500mg ☐ 650mg ☐ 1000mg PO

☐ Other orders:

Signature (required)

PHYSICIAN SIGNATURE DATE