



**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: <input type="checkbox"/> M <input type="checkbox"/> F	Weight:
Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> 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		
<input type="checkbox"/> Primary Immunodeficiency	ICD 10:	Year of Diagnosis:
<input type="checkbox"/> Other:	ICD 10:	Year of Diagnosis:

INSURANCE INFORMATION			
<i>Please submit copies of the front and back or primary and secondary insurance cards with this referral.</i>			
Primary Insurance:	ID#	Secondary Insurance:	ID#

PRESCRIPTION INFORMATION (requires new order every 12 months)	
<i>Medication may be substituted with payer-preferred brand, generic, or biosimilar equivalent per authorization and institutional formulary</i>	
Medication: <b>Immune Globulin</b> ____%	<b>PRE-MEDICATIONS:</b> <input type="checkbox"/> N/A
Administer: ____ Grams at ____ mg/kg	<input type="checkbox"/> Acetaminophen: <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO
per day over ____ days, every ____	<input type="checkbox"/> Loratadine (Claritin): 10mg PO
weeks	<input type="checkbox"/> Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> PO <input type="checkbox"/> IV
Infusion rate will be titrated per	<input type="checkbox"/> Dexamethasone: <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 20 mg IV
manufacturer recommendations according to	<input type="checkbox"/> Famotidine: <input type="checkbox"/> 20 mg IV
diagnosis/indication and patient weight	
<i>Doses will be rounded to nearest 5 Grams</i>	<b>POST-MEDICATIONS</b>
<input checked="" type="checkbox"/> Vital signs per clinic protocol	<input type="checkbox"/> Acetaminophen: <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO
<input checked="" type="checkbox"/> Infusion reaction/Hydration Management	<input type="checkbox"/> Other orders:
per clinic protocol	_____
	_____

Signature (required)	
PHYSICIAN SIGNATURE	DATE