

# Intravenous Immune Globulin (IVIG) | Order Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**1. For new patients, please submit with form:**

- Copy of insurance card
- Patient demographics
- Testing results supporting diagnosis
- History & physical
- Labs
- Baseline assessment (include any tried/failed therapies)

**2. Patient Information**

Male Female Height: \_\_\_\_\_ in cm Weight: \_\_\_\_\_ lbs kg NKDA Allergies: \_\_\_\_\_  
 Has patient been on IG (IV or SQ) before? Yes No If yes, indicate product/relevant information: \_\_\_\_\_  
 Date of last IG infusion (if known): \_\_\_\_\_ Desired start date / next dose due: \_\_\_\_\_  
 Line: PIV PICC Port Other: \_\_\_\_\_ Any additional information: \_\_\_\_\_

**3. Diagnosis and Clinical Information**

ICD-10 (required): \_\_\_\_\_ Primary diagnosis (or check below): \_\_\_\_\_  
 CIDP Congenital hypogammaglobulinemia CVID Dermatomyositis ITP Guillain-barré syndrome  
 Multifocal motor neuropathy Multiple sclerosis Myasthenia gravis Polymyositis SCID

**4. Prescription Information**

<b>IVIG Product</b>	IVIG: Pharmacist to select product based on patient specific factors and notify provider of selection or change Dispense as written, IVIG brand required: _____ Additional information: _____
<b>Dose and Frequency</b>	<b>Loading</b> dose: _____ grams OR _____ grams/kg, IV divided over _____ day(s) one time <b>Maintenance:</b> _____ grams OR _____ grams/kg, IV divided over _____ days(s) every _____ weeks for _____ cycles <b>Other:</b> _____ <b>If weight is &gt;130% ideal body weight (IBW), use adjusted body weight (IBW+0.4[ABW-IBW]) to calculate dose</b> Dose to be rounded to whole vial size per PromptCare Policy and Procedure unless otherwise indicated
<b>Rate</b>	Infuse IV per manufacturer guidelines OR over _____ hours. Titrate rate according to protocol, as tolerated
<b>Quantity / Refills</b>	Dispense 1 month supply / Refill x 12 months OR Other: _____ Dispense all medical supplies necessary for infusion

**5. Additional Orders**

RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per PromptCare Policy and Procedure

**Premedications:** Give 30 min prior to infusions (*Note: if nothing is checked, no premedications will be given*)

**Adults (or patients weighing >40kg):**

Diphenhydramine 25-50mg PO. Patient may decline.  
 Acetaminophen 325-650mg PO. Patient may decline.  
 Methylprednisolone 40mg (OR \_\_\_\_\_ mg) slow IV push  
 (or an equivalent corticosteroid, substitution if needed by pharmacy)

**Pediatrics (weighing <40 kg):** (*may adjust with weight changes*)

Diphenhydramine 1mg/kg PO  
 Acetaminophen 15mg/kg PO  
 Methylprednisolone 1 mg/kg (OR \_\_\_\_\_ mg) slow IV push (or  
 an equivalent corticosteroid, substitution if needed by pharmacy)

Other: \_\_\_\_\_  
 RN to instruct patient to hydrate pre/post infusion and educate on taking OTC diphenhydramine and/or acetaminophen per manufacturer dosing  
 recommendations as needed to prevent/treat post-infusion headache.  
 RN to monitor patient for at least 30 minutes post infusion and educate on possible side effects, allergic reaction, and when to contact provider

**6. Adverse Reaction Orders**

Standard anaphylaxis kit to be dispensed and dosed per protocol: Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM  
 (50 mg/mL), and NS IV. Additional orders: \_\_\_\_\_

**7. Prescriber Information**

Prescriber Name: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 License #: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI: \_\_\_\_\_

\_\_\_\_\_  
**Physician Signature (Substitution Permitted)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Physician Signature (Dispense as Written)**

\_\_\_\_\_  
**Date**

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