

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
☐ History & physical
☐ Testing results supporting diagnosis

☐ Patient demographics
☐ Labs
☐ Baseline assessment (include medications tried and failed if any)

2. Patient Information

☐ Male ☐ Female Height: _____ in/cm Weight: _____ lbs/kg ☐ NKDA Allergies: _____
 Has patient been on IG (IV or SQ) before? ☐ No ☐ Yes, list IG product and dose/frequency: _____
 Date of last IG infusion (if known): _____ Is patient currently on **SCIG** and transitioning to IVIG? ☐ Yes ☐ No
 List **SCIG** product, dose/frequency: _____ Desired start date for IVIG (if known): _____
 Line: ☐ PIV ☐ PICC ☐ Port ☐ Other

3. Diagnosis and Clinical Information

ICD-10 (required): _____
 Primary diagnosis: ☐ Congenital hypogammaglobulinemia ☐ CVID ☐ SCID ☐ CIDP ☐ Multifocal motor neuropathy ☐ Multiple sclerosis
☐ Guillain-barré syndrome ☐ Myasthenia gravis ☐ Polymyositis ☐ Dermatomyositis ☐ ITP ☐ Other: _____

4. Prescription Information

IVIG Product	<input type="checkbox"/> IVIG: Pharmacist to select product based on patient specific factors and notify provider of selection or change* *Changing IVIG products is only recommended if necessary, and will be discussed with provider before any change is made <input type="checkbox"/> Dispense as written, IVIG brand required: _____ Additional information: _____
Dose / Frequency	Initial/loading dose: _____ g/kg* (OR _____ grams) IV divided over _____ day(s) one time Maintenance dose: _____ g/kg* (OR _____ grams) IV divided over _____ days(s) every _____ weeks for _____ cycles Other: _____ <input type="checkbox"/> *If weight is >130% ideal body weight (IBW), use adjusted body weight (IBW+0.4[ABW-IBW]) to calculate dose <input type="checkbox"/> Round dose to whole vial size per policy
Administration	Infuse IV per manufacturer guidelines OR over _____ hours*. Titrate rate according to protocol, as tolerated. <i>*Note: Patients at risk for thrombosis or renal dysfunction should receive minimum dose and infusion rate practicable</i>
Quantity / Refills	Dispense 1 month supply; Refill x 12 months <input type="checkbox"/> 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)

☐ Other: _____

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: _____

☐ 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 min post infusion and educate on possible side effects, allergic reactions, and when to contact physician.

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 vial), and NS IV.
 Additional orders: _____

7. Prescriber Information

Prescriber Name: _____ Office Contact: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 License No.: _____ DEA NO.: _____ NPI: _____

Physician Signature (Substitution Permitted)

Date

Physician Signature (Dispense as Written)

Date