

# 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. IVIG Prescription Information

|                           |                                                                                                                                                                                                                                                                                                                                                                     |
|---------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Dose and Frequency</b> | <b>Loading dose:</b> _____ 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>             | <ul style="list-style-type: none"> <li>• Dose to be rounded to whole vial size per PromptCare Policy and Procedure</li> <li>• If weight is &gt;130% ideal body weight (IBW), doses ordered in grams/kg will be calculated using adjusted body weight (IBW+0.4[ABW-IBW]) unless otherwise ordered: Use actual body weight even if patient is &gt;130% IBW</li> </ul> |
| <b>Rate</b>               | Infuse IV per manufacturer guidelines (OR over _____ hours). Titrate rate according to protocol, as tolerated                                                                                                                                                                                                                                                       |
| <b>Product</b>            | Pharmacy to select clinically suitable Ig brand and notify provider of selection or change, unless Ig brand is specified by prescriber: _____                                                                                                                                                                                                                       |
| <b>Quantity / Refills</b> | Dispense 1 month supply (or quantity sufficient per order above) / Refill x 12 months unless otherwise noted<br>Other: _____<br>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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