

Fax: 800-815-6808 IVIG@promptcare.com



Intravenous Immune Globulin (IVIG) | Order Form

		DOB:	Pho	ne:		
ldress:		DOB: City:	· · · · · · · · · · · · · · · · · · ·	State:	Zip:	
For new patie Copy o	nts, please submit with f	orm: Patient demographics	Testing results	supporting diagno	osis	
Patient Inforn	• •			·		
Has patient been Date of last IG in	on IG (IV or SQ) before? fusion (if known):	in cm Weight: Yes No If yes, indic Desired start date / Any additional ir	ate product/relevant info next dose due:	ormation:		
	d Clinical Information	•				
ICD-10 (required CIDP Multifoca):	Primary diagnosis (naglobulinemia CVID Multiple sclerosis	Dermatomyositis	ITP Polymyositis	Guillain-barré SC	
Dose and	Loading dose:	grams OR gram	s/kg, IV divided over	day(s) one time	<u> </u>	
Frequency		grams OR grams/kg				_ cycles
	Dose to be rounded toIf weight is >130% id	o whole vial size per Promp eal body weight (IBW), do /-IBW]) unless otherwise o	ses ordered in grams/k	g will be calculated		
Rate	Infuse IV per manufacture	er guidelines (OR over	hours). Titrate rat	e according to pro	otocol, as tolera	ted
Product	Pharmacy to select clinically suitable Ig brand and notify provider of selection or change, unless Ig brand is specified by prescriber:					
Quantity /	Dispense 1 month supply (or quantity sufficient per order above) / Refill x 12 months unless otherwise noted Other:					
Refills						
	Dispense all medical sup	plies necessary for infusion				
Additional Or	Dispense all medical sup	plies necessary for infusion C. RN to administer catheter flu		icy and Procedure		
Additional Or RN to start pe Premedicatio	Dispense all medical sup ders ripheral IV or use existing CV ns: Give 30 min prior to in	C. RN to administer catheter flu	ushing per PromptCare Po Checked, no premedicat	ions will be given)		
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