

# Intravenous Immunoglobulin (IVIG)



Provider Order Form rev. 2/4/26

## PATIENT INFORMATION

Referral Status:  New Referral  Updated Order  Order Renewal

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

ICD-10 code (required): \_\_\_\_\_ ICD-10 description: \_\_\_\_\_

NKDA Allergies: \_\_\_\_\_ Weight (lbs/kg): \_\_\_\_\_ Height: \_\_\_\_\_

Patient Status:  New to Therapy  Continuing Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

## PROVIDER INFORMATION

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## NURSING

- Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation  
**NOTE:** IVX Adverse Reaction Management Protocol available for review at [www.ivxhealth.com/forms](http://www.ivxhealth.com/forms) (version 05.01.2023)

## LABORATORY ORDERS

- CBC  at each dose  every \_\_\_\_\_  
 CMP  at each dose  every \_\_\_\_\_  
 Other: \_\_\_\_\_

## PRE-MEDICATION ORDERS

- acetaminophen (Tylenol)  500mg /  650mg /  1000mg PO  
 cetirizine (Zyrtec) 10mg PO  
 loratadine (Claritin) 10mg PO  
 diphenhydramine (Benadryl)  25mg /  50mg  PO /  IV  
 methylprednisolone (Solu-Medrol)  40mg /  125mg IV  
 hydrocortisone (Solu-Cortef)  100mg IV  
 Other: \_\_\_\_\_  
Dose: \_\_\_\_\_ Route: \_\_\_\_\_  
Frequency: \_\_\_\_\_

## THERAPY ADMINISTRATION

## APPEALS PROCESS

Upon denial, IVX will appeal with a Letter of Medical Necessity unless you opt out:  Opt out (I will manage any denial)

IVX will select the product based on payor requirements, product availability, and indication:

**Asceniv, Gammagard Liquid, Gammagard S/D, Gamunex-C, Octagam, Panzyga, Privigen**

Loading dose (if applicable): \_\_\_\_\_ gm/kg or \_\_\_\_\_ gm x \_\_\_\_\_ day(s) or divided over \_\_\_\_\_ day(s)

Initiate maintenance dose: \_\_\_\_\_ week(s) after the loading dose

Maintenance dose: \_\_\_\_\_ gm/kg or \_\_\_\_\_ gm x \_\_\_\_\_ day(s) or divided over \_\_\_\_\_ day(s) every \_\_\_\_\_ weeks

Other (Indicate dose and frequency): \_\_\_\_\_

## SPECIAL INSTRUCTIONS

- Administration rate: IVX Health will establish the administration rate based on therapy prescribing information.

REFILLS:  Zero /  for 12 months /  \_\_\_\_\_  
(if not indicated order will expire one year from date signed)

Provider Name (Print)

Provider Signature

Date

## IVX HEALTH FAX NUMBERS

ARKANSAS: 501-451-5644

AUSTIN: 512-772-2824

BAY AREA: 844-889-0275

CHARLOTTE: 336-663-0143

CHICAGO: 312-253-7244

CINCINNATI: 844-946-0868

COLLEGE STN: 979-205-4686

COLUMBUS: 844-627-2675

CONNECTICUT: 860-955-1532

DALLAS: 469-947-6114

DAYTONA: 386-259-6096

DELAWARE: 302-596-8553

EAST TN/TRI-CITIES: 615-425-7427

FT. LAUDERDALE: 754-946-2052

HARRISBURG: 844-859-4235

HOUSTON: 832-631-9595

INDIANAPOLIS: 844-983-2028

JACKSONVILLE: 904-212-2338

KANSAS CITY: 844-900-1292

LAKELAND: 863-316-3910

MELBOURNE: 321-800-9515

MIAMI: 786-744-5687

MIDDLE/WEST TN: 888-615-1445

NORTH CENTRAL FL: 352-756-4191

NORTH JERSEY: 551-227-2823

NYC: 332-334-0809

ORLANDO: 844-946-0867

PALM BEACH: 561-768-9044

PHILADELPHIA: 844-820-9641

PIEDMONT TRIAD: 336-790-2200

RALEIGH: 919-287-2551

SAN ANTONIO: 726-238-9950

SARASOTA: 941-870-6550

SOUTH JERSEY: 856-519-5309

SOUTHWEST FL: 813-283-9144

TAMPA: 844-946-0849

WACO: 254-343-7650