Intravenous Immunoglobulin (IVIG)

IVX HEALTH

Provider Order Form rev. 11/11/26

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 (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: _____

APPEALS PROCESS

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

THERAPY ADMINISTRATION

IVX will select the product based on payor requirements, product availability, and indication:
Asceniv, Alyglo, Bivigam, Gammagard Liquid, Gammagard S/D, Gamunex-C, Octagam, Panzyga, Privigen, and Qivigy

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
☐ CENTRAL JERSEY: 640-252-6633
☐ 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
☐ COOKEVILLE: 931-479-1395
☐ DALLAS: 469-947-6114
☐ DAYTONA: 386-259-6096
☐ DELAWARE: 302-596-8553
☐ EAST TN/TRI-CITIES: 615-425-7427
☐ FT. LAUDERDALE: 754-946-2052
☐ FT. WAYNE: 260-369-2310
☐ 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
☐ LONG ISLAND: 363-201-6975
☐ MELBOURNE: 321-800-9515
☐ MIAMI: 786-744-5687
☐ MIDDLE/WEST TN: 888-615-1445
☐ NC FL: 352-756-4191
☐ NORTH JERSEY: 551-227-2823
☐ NYC: 332-334-0809
☐ ORANGE COUNTY: 949-590-4554
☐ 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