Intravenous Immunoglobulin 10% (IVIG 10%)

IVX HEALTH

Provider Order Form rev. 5/9/2022

PATIENT INFORMATION

Date: Patient Name: DOB:

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

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable): 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 09.07.2021)

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

IVX will select the product based on payor requirements, product availability, and indication: Gammagard Liquid, Gammagard SD, Octagam, Bivigam, or Asceniv.

Choose an Indication below.

☐ **Primary Immunodeficiency (PI)**	_____ mg/kg (ref range 100-800mgmg/kg every 3-4 weeks
☐ **Chronic Inflammatory demyelinating polyneuropathy (CIDP)**	***Loading***: _____ gm/day x _____ days; OR _____ gm/kg/course divided over _____ days (ref range 2g/kg) ***Maintenance***: _____ gm/day x _____ days; OR _____ gm/kg/course divided over _____ days (ref range 1g/kg every 3 wks)
☐ **Multifocal motor neuropathy (MMN)**	_____ gm/day x _____ days; OR _____gm/kg/course divided over _____ days (ref range 0.5- 2.4gm/kg)
☐ **Idiopathic thrombocytopenia purpura (ITP)**	1g/kg. Up to three separate doses may be given on alternate days
☐ **OTHER** *Include dosage, frequency and any other special instructions	****WRITE INSTRUCTIONS HERE***

☑ Flush with 5% dextrose in water (D5W) at completion of infusion
☐ Patient is required to stay for 30-minute observation post infusion

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

Provider Name (Print) **Provider Signature** **Date**

FAX NUMBERS

Fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:

☐ BAY AREA: 844-889-0275	☐ DAYTONA: 386-259-6096	☐ KANSAS CITY: 844-900-1292	☐ SOUTHWEST FL: 813-283-9144
☐ CHARLOTTE: 336-663-0143	☐ HARRISBURG: 844-859-4235	☐ ORLANDO: 844-946-0867	☐ TAMPA: 844-946-0849
☐ CINCINNATI: 844-946-0868	☐ HARTFORD: 860-955-1532	☐ PALM BEACH: 561-768-9044	☐ WEST TN/AR: 888-615-1445
☐ CHICAGO: 312-253-7244	☐ INDIANAPOLIS: 844-983-2028	☐ PHILADELPHIA: 844-820-9641	☐ MIDDLE TN: 888-615-1445
☐ COLUMBUS: 844-627-2675	☐ JACKSONVILLE: 904-212-2338	☐ SARASOTA: 941-870-6550	☐ EAST TN: 615-425-7427