

Intravenous Immunoglobulin 10% (IVIG 10%)



Provider Order Form rev. 1/4/24

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)

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: _____

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- Other: _____

THERAPY ADMINISTRATION

IVX will select the product based on payor requirements, product availability, and indication: Gamunex-C, Gammagard Liquid, Gammagard SD, HyQvia, Octagam, and Privigen.

Choose an Indication below.

- Primary Immunodeficiency (PI) _____ mg/kg (ref range 100-800mg/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 **WRITE INSTRUCTIONS HERE**
*Include dosage, frequency and any other special instructions

- Flush with 5% dextrose in water (D5W) at completion of infusion
 - Patient is required to stay for 30-minute observation
- REFILLS: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

Provider Name (Print) _____ Provider Signature _____ Date _____

FAX NUMBERS

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> AUSTIN: 512-772-2824 | <input type="checkbox"/> CONNECTICUT: 860-955-1532 | <input type="checkbox"/> INDIANAPOLIS: 844-983-2028 | <input type="checkbox"/> NORTH CENTRAL FL: 352-756-4191 | <input type="checkbox"/> RALEIGH: 919-287-2551 |
| <input type="checkbox"/> BAY AREA: 844-889-0275 | <input type="checkbox"/> DAYTONA: 386-259-6096 | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> NORTH JERSEY: 551-227-2823 | <input type="checkbox"/> SAN ANTONIO: 726-238-9950 |
| <input type="checkbox"/> CHARLOTTE: 336-663-0143 | <input type="checkbox"/> DELAWARE: 302-596-8553 | <input type="checkbox"/> KANSAS CITY: 844-900-1292 | <input type="checkbox"/> NORTHWEST AR: 888-615-1445 | <input type="checkbox"/> SARASOTA: 941-870-6550 |
| <input type="checkbox"/> CHICAGO: 312-253-7244 | <input type="checkbox"/> EAST TN: 615-425-7427 | <input type="checkbox"/> LAKE LAND: 863-316-3910 | <input type="checkbox"/> ORLANDO: 844-946-0867 | <input type="checkbox"/> SOUTH JERSEY: 856-519-5309 |
| <input type="checkbox"/> CINCINNATI: 844-946-0868 | <input type="checkbox"/> FT. LAUDERDALE: 754-946-2052 | <input type="checkbox"/> LITTLE ROCK: 501-451-5644 | <input type="checkbox"/> PALM BEACH: 561-768-9044 | <input type="checkbox"/> SOUTHWEST FL: 813-283-9144 |
| <input type="checkbox"/> COLUMBUS: 844-627-2675 | <input type="checkbox"/> HARRISBURG: 844-859-4235 | <input type="checkbox"/> MIAMI: 786-744-5687 | <input type="checkbox"/> PHILADELPHIA: 844-820-9641 | <input type="checkbox"/> TAMPA: 844-946-0849 |
| | <input type="checkbox"/> HOUSTON: 832-631-9595 | <input type="checkbox"/> MIDDLE TN: 888-615-1445 | <input type="checkbox"/> PIEDMONT TRIAD: 336-790-2200 | <input type="checkbox"/> WEST TN: 888-615-1445 |