# Intravenous Immunoglobulin 10% (IVIG 10%)

IVX HEALTH

***Provider Order Form*** rev. 9/28/2021

## 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):

## 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
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

## THERAPY ADMINISTRATION

| | |
|---|---|
| ☐ **Gammagard Liquid** | ☐ (PI)_____ (ref range 300-600mg/kg) IV every 3-4 weeks<br>☐ (MMN) ____ gm/day x _____ days; OR _____gm/kg/course divided over _____ days (ref range 0.5- 2.4gm/kg) IV once per month |
| ☐ **Gammaked** | ☐ (ITP) _____ gm/day x _____ days; OR _____gm/kg/course divided over _____ days (ref range 2g/kg)<br>☐ (CIDP) Loading dose-_____gm/day x _____ days; OR _____gm/kg/course divided over _____ days (ref range loading dose 2g/kg)<br>☐ (CIDP) Maintenance _____gm/day x _____ days; OR _____gm/kg/course divided over _____ days (ref range 1g/kg every 3 weeks)<br>☐ (PI) _____mg/kg (ref range 300-600mg/kg) every 3-4 weeks |
| ☐ **Octagam** | ☐ 5% (PI) _____mg/kg (ref range300-600 mg/kg) IV every 3-4 weeks<br>☐ 10% (Chronic ITP) 1 g/kg daily for 2 consecutive days (Administer Octagam 10% at a total dose of 2 g/kg, divided into two doses of 1 g/kg (10 Ml/kg) given on two consecutive days.) |
| ☐ **Asceniv** | ☐ (PI) _____mg/kg (ref range 300-800mg/kg) IV every 3-4 weeks |
| ☐ **Bivigam** | ☐ (PI) _____mg/kg (ref range 300-800mg/kg) IV every 3-4 weeks |
| ☐ **Gammagard S-D** | ☐ (PI) _____mg/kg (ref range 100-400mg/kg) IV once monthly<br>☐ (ITP) 1g/kg. Up to three separate doses may be given on alternate days |

☐ If product unavailable, a different therapy listed above may be administered.
☐ If product unavailable, contact provider to discuss therapy options.
☑ Flush with 5% dextrose in water (D5W) at completion of infusion

☐ Patient is required to stay for 30-minute observation post infusion
☐ Patient is NOT required to stay for observation time
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

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

**Email ivxintake@ivxhealth.com or fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:**

| | | | | |
|---|---|---|---|---|
| ☐ BAY AREA: 844-899-0275 | ☐ COLUMBUS: 844-627-2675 | ☐ JACKSONVILLE: 904-212-2338 | ☐ PHILADELPHIA: 844-820-9641 | ☐ WEST TN: 888-615-1445 |
| ☐ CINCINNATI: 844-946-0868 | ☐ HARRISBURG: 844-859-4235 | ☐ KANSAS CITY: 844-900-1292 | ☐ TAMPA: 844-946-0849 | ☐ MIDDLE TN: 888-615-1445 |
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