



INFUSION ORDERS- IVIG (IMMUNOGLOBULIN)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS		
<input type="checkbox"/> New Referral	<input type="checkbox"/> Dose or Frequency Change	<input type="checkbox"/> Order Renewal

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Diagnosis: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Serum Ab Titers to pneumococcus or tetnus/diphtheria, when applicable	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> IgG level and subclass test results, when applicable
List Tried & Failed Therapies, including duration of treatment:	
1)	
2)	
3)	

MEDICATION ORDERS	
IVIG Brand (Choose one)	<input type="checkbox"/> Gammagard 10% <input type="checkbox"/> Other: _____ If Hyqvia (subcutaneous injection) is preferred, please refer to website for Hyqvia form.
Weight-Based Dosing** (Dose may change with fluctuations in weight)	<i>Please indicate frequency in the blank space provided.</i> <input type="checkbox"/> 0.4 gm/kg IV _____ <input type="checkbox"/> 1 gm/kg IV _____ <input type="checkbox"/> 2 gm/kg IV _____ <input type="checkbox"/> Other: _____
Flat Dosing	<input type="checkbox"/> _____ gm IV _____
Patient Weight = _____ kg** Note: If patient is obese, ideal body weight (IBW) should be used	
Refills: <input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses	

**Patient weight is required for weight-based orders

All IVIG infusion rates will be titrated as recommended in prescribing information.

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

Contact us with questions at: info@rosenursing.net
or call **954.432.8290**

Fax completed form and all documentation to **844.246.3364**

All information contained in this form is strictly confidential and will become part of the patient's medical record.