LIFE SPECIALTY SOLUTIONS

# IVIG

## PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

DATE OF BIRTH: _____ EMAIL: _____

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

### REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Most Recent Labs 5. Medication List 6. Current IG Levels

## PRIMARY DIAGNOSIS

| | | |
|---|---|---|
| ☐ C91.0 Acute lymphoblastic leukemia [ALL] | ☐ G35 Multiple sclerosis | ☐ M33.20 Polymyositis, organ involvement unspecified |
| ☐ D80.1 Nonfamilial hypogammaglobulinemia | ☐ G61.81 Chronic inflammatory demyelinating polyneuritis | ☐ M33.22 Polymyositis with myopathy |
| ☐ D80.3 Selective deficiency of immunoglobulin G [IgG] subclasses | ☐ G61.82 Multifocal motor neuropathy | ☐ M33.90 Dermatopolymyositis, unspecified, organ involvement unspecified |
| ☐ D80.9 Immunodeficiency with predominantly antibody defects, unspecified | ☐ G70.00 Myasthenia gravis without (acute) exacerbation | ☐ M72.6 Necrotizing fasciitis |
| ☐ D83.0 Com variable immunodeficiency w/ predominantabnlt of B-cell nums & function | ☐ G70.01 Myasthenia gravis with (acute) exacerbation | ☐ T86.10 Unspecified complication of kidney transplant |
| ☐ D83.1 Com variable immunodefiency w/ predominant immunoreg T-cell disorder | ☐ G72.49 Oth inflammatory and immune myopathies, NEC | ☐ T86.11 Kidney transplant rejection |
| ☐ D83.9 Common variable immunodeficiency, unspecified | ☐ J84.9 Interstitial pulmonary disease, unspecified | ☐ Z94.0 Kidney transplant status |
| | ☐ L10.0 Pemphigus vulgaris | ☐ Other:_____ |
| | ☐ M33.13 Other dermatomyositis without myopathy | |

## LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

## PRE-MEDICATIONS

☑ Per infusion clinic protocol: There are no recommended standard pre-meds

☐ Provider Prescribed: _____

## PRIMARY MEDICATION ORDER

**No Brand Preference:** **If Brand Preference:**

☐ No brand preference - Immune Globulin Solution 5% ☐ Gamunex-C 10% ☐ Gammagard Liquid 10% ☐ Octagam 5% ☐ Octagam 10%

☐ No brand preference - Immune Globulin Solution 10% ☐ Privigen 10% ☐ Bivigam 10% ☐ Panzyga 10% ☐ _____

**Dosing:** ☐ _____GRAMS/kg or _____GRAMS IV divided equally over _____ days every _____ weeks

☐ _____milligrams/kg or_____milligrams IV divided equally over _____ days every _____ weeks

*Dose will be rounded to the nearest 5g vial size.
To prohibit dose rounding, check here ☐

☐ Other _____ FIRST DOSE?: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted.

## LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)

☐ Other Flush Orders: Please send other line care orders if checking this box

## ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)

☐ Other: (Please send other reaction orders if checking this box)

## PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____

OFFICE CONTACT: _____ FAX: _____

ADDRESS: _____ EMAIL: _____

CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

✖ _____ _____

PROVIDER SIGNATURE DATE