

IVIG Infusion Order

**Fax completed order to: 334-521-0394**

1925 East Glenn Ave. Suite 203

Auburn, AL 36830

334-521-0073

# InfusionCare.org

**P: 334-521-0073**

Demographics Insurance Information H & P Relevant to the Diagnosis BUN & Creat (within the last 30 days) IgG Dates & Results of Pneumo titers/vaccine

**This information is necessary for prior authorization approval and to ensure payment by the insurance carrier.**

**\*Please fax a copy of the following patient information:**

**IVIG Treatment**

**(Choose one)**

Bivigam

Gammagard 10%

Gamunex-C 10%

Octagam 5%

Panzyga

Privigen

Other

**Patient Information**

Date of Referral

First Name M.I. Last Name

Date of Birth

Address

City State Zip Code

Phone

Wt (kg) Ht (in)

Diagnosis

Office Contact Person

Office Contact Email or Phone Number

**Pre/Post meds and nursing orders on 2nd page**

⃝ D84.89 Primary Immunodeficiency

⃝

Prescribing Provider

Address

City State Zip Code

Provider Phone

Provider Fax

Provider NPI Provider Tax ID

**Provider Signature (No Stamps)**

Date/Time

**Infusion Care of East Alabama** [**www.infusioncare.org**](http://www.infusioncare.org) **334-521-0073**

IVIG Infusion Order

Text

Description automatically generated

Logo

Description automatically generated with low confidence

**Pre/Post Medications and Nursing Orders**

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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Route: Intravenous

Maintenance Dose: ▢\_\_\_\_\_\_grams ▢\_\_\_\_\_\_mg/kg = \_\_\_\_\_\_grams

Patient’s Weight:\_\_\_\_\_\_\_\_\_\_kg Date of Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

▢ Infuse every \_\_\_\_\_\_\_\_\_\_Week(s)

▢ Follow Package Insert Infusion Rate Instructions for new patients; slowly advance rate to max tolerated rate and within Package Insert

▢ Infuse at \_\_\_\_\_\_\_\_ml/hr or infuse over \_\_\_\_\_\_\_\_ hours

▢ Patient only tolerates infusion over\_\_\_\_\_\_\_hours or at max rate of\_\_\_\_\_\_\_\_ml/hr

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|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Route | Dose/Strength | Directions |
| Catheter:  ▢ PIV ▢ Port | IV | NA | PIV: Flush before & after with NS 5mL  Port: ▢ NS 10mL & Heparin 100 u/mL 3-5mL Port: ▢ 10 mL sterile saline to access port  Port: ▢ Other: |
| Hydration:  ▢ LR ▢ NS | IV | ▢ Pre ▢Concurrent ▢Post  ▢ 500 mL ▢ 1,000 mL | ▢ Hydration max rate up to \_\_\_\_\_\_mL/hr |
| Inflammation:  ▢ Solu-Cortef | IV | 100 mg | Infuse 100 mg over 30 sec by IV route prior to Ig infusion monthly x 3 |
| ▢ Diphenhydramine | ▢ PO  ▢ IV  ▢ IM | ▢ 25 mg  ▢ 50 mg  ▢ 10mg IV Push | ▢ Premed 30 min prior to infusion  ☑ Standing order to treat reaction (refer to Reaction Treatment Record) |
| ▢ Acetaminophen | PO | ▢ 325 mg  ▢ 650 mg | ▢ Premed 30 min prior to infusion  ▢ May repeat every 4-6 hours PRN (Adult max 2000mg/day) |
| ▢Epinephrine | IM | 0.3 mL of 1:1000  (for patients >30kg/>66lbs) | ☑ Standing order to treat reaction (refer to Reaction Treatment Record) |

▢ Other:

**Provider Signature (No Stamps)**

Date/Time

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Quantity: ▢ 1cycle ▢ 1month ▢ 3 months ▢ Other: Refills: ▢ 6 ▢ 1year

**Rx Includes related diluents, pumps, DME, ancillary supplies (e.g. needles, syringes, etc) as necessary for drug administration and/or catheter maintenance**

**Physician Signature Required**

**Dispense as written (Date) Product substitution permitted (Date)**

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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