

Intravenous Immune Globulin (IVIG) | Order Form

Patient Name: _____ DOB: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____

1. For new patients, please submit with form:

- Copy of insurance card
- Patient demographics
- Testing results supporting diagnosis
- History & physical
- Labs
- Baseline assessment (include any tried/failed therapies)

2. Patient Information

Male Female Height: _____ in cm Weight: _____ lbs kg NKDA Allergies: _____

Has patient been on IG (IV or SQ) before? Yes No If yes, indicate product/relevant information: _____

Date of last IG infusion (if known): _____ Desired start date / next dose due: _____

Line: PIV PICC Port Other: _____ Any additional information: _____

3. Diagnosis and Clinical Information

ICD-10 (required): _____ Primary diagnosis (or check below): _____
 CIDP Congenital hypogammaglobulinemia CVID Dermatomyositis ITP Guillain-barré syndrome
 Multifocal motor neuropathy Multiple sclerosis Myasthenia gravis Polymyositis SCID

4. Prescription Information

IVIG Product	IVIG: Pharmacist to select product based on patient specific factors and notify provider of selection or change Dispense as written, IVIG brand required: _____ Additional information: _____
Dose and Frequency	Loading dose: _____ grams OR _____ grams/kg, IV divided over _____ day(s) one time Maintenance: _____ grams OR _____ grams/kg, IV divided over _____ days(s) every _____ weeks for _____ cycles Other: _____ If weight is >130% ideal body weight (IBW), use adjusted body weight (IBW+0.4[ABW-IBW]) to calculate dose Dose to be rounded to whole vial size per Coastal Infusion Services Policy and Procedure unless otherwise indicated
Rate	Infuse IV per manufacturer guidelines OR over _____ hours. Titrate rate according to protocol, as tolerated
Quantity / Refills	Dispense 1 month supply / Refill x 12 months OR Other: _____ Dispense all medical supplies necessary for infusion

5. Additional Orders

RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per Coastal Infusion Services Policy and Procedure

Premedication: Give 30 min prior to infusions (Note: if nothing is checked, no premedication will be given)

Adults (or patients weighing >40kg):

Diphenhydramine 25-50mg PO. Patient may decline.
Acetaminophen 325-650mg PO. Patient may decline.
Methylprednisolone 40mg (OR _____ mg) slow IV push
(or an equivalent corticosteroid, substitution if needed by pharmacy)

Pediatrics (weighing <40 kg): (may adjust with weight changes)

Diphenhydramine 1mg/kg PO
Acetaminophen 15mg/kg PO
Methylprednisolone 1 mg/kg (OR _____ mg) slow IV push (or
an equivalent corticosteroid, substitution if needed by pharmacy)

Other: _____

RN to instruct patient to hydrate pre/post infusion and educate on taking OTC diphenhydramine and/or acetaminophen per manufacturer dosing recommendations as needed to prevent/treat post-infusion headache.

RN to monitor patient for at least 30 minutes post infusion and educate on possible side effects, allergic reaction, and when to contact provider

6. Adverse Reaction Orders

Standard anaphylaxis kit to be dispensed and dosed per protocol: Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL), and NS IV. Additional orders: _____

7. Prescriber Information

Prescriber Name: _____ Office Contact: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

License #: _____ DEA #: _____ NPI: _____

Physician Signature (Substitution Permitted)

Date

Physician Signature (Dispense as Written)

Date

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