INFUSACARE
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IVIG Infusion Order

Patient Name: _____ DOB: _____ □ Male □ Female

Diagnosis (please provide ICD10 code): _____

□ Other: _____

□ NKDA □ Allergies: _____

□ New Therapy Order □ Continuation of Therapy Date of last dose: _____

Ordering Provider Name: _____

Provider NPI: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Pre-Medication

□ Acetaminophen _____mg by □ PO
□ Cetirizine _____mg by □ PO
□ Diphenhydramine _____mg by □ PO/ □ IVP
□ Solu-Medrol _____mg by □ PO/ □ IVP
□ Solu-Cortef _____mg by □ PO/ □ IVP
□ Other: _____

Required Documentation:

□ Patient Demographics
□ Patient Insurance (med and pharm card copies, front and back)
□ Progress Notes/Labs supporting diagnosis
□ CBC, CMP
□ Other: _____

IVIG medications may be weight based:

Patient Height (cm): _____ Patient Weight (kg): _____

IVIG Medication Order:

- Specific Medication (choose one):
  - □ Gammagard (10%)
  - □ Gammaked (10%)
  - □ Gammunex-C (10%)
  - □ Octagam (10%)
  - □ Panzyga (10%)
  - □ Asceniv (10%)
  - □ *Infusion Center's Discretion*
  - □ Other: _____
- Intravenous Dosage and Frequency (choose one):
  - □ _____ g/day x _____ days
  - □ _____ mg/kg every _____ weeks for _____ doses
  - □ One-time dose of _____
  - □ Other: _____

Additional Instructions/Notes:

Patient IV Access

□ PIV
□ Use patient's SL/DL PICC, flush per protocol
□ Access/deaccess patient's Port, flush per protocol
*Imaging results of proper placement required for PICC/Port

Ordering Provider:

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____

Locations:

□ *Skokie, IL*: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141
□ *Libertyville, IL*: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141
□ *Orland Park, IL*: 16612 107th Ct, Ste B. P: 847-324-6800. F: 224-251-7141
□ *Houston, TX*: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400