SPECIALTY INFUSION CENTERS

IMMUNE GLOBULIN FORM

FAX TO: 800-540-1852

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F

Ht: _____ WT: _____ lbs / kg Primary Language: _____ Allergies: _____

Patient Preferred Location: ☐ Staten Island ☐ West Harrison ☐ Manhattan ☐ New Paltz ☐ Bronx ☐ Syosset ☐ Port Jefferson ☐ Millburn ☐ Brooklyn Heights ☐ Paramus

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

- ☐ D80._____ Hypogammaglobulinemia or Select IG Deficiency
- ☐ D83._____ Common Variable Immune Deficiency
- ☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy
- ☐ M33.9_____ Dermatopolymyositis
- ☐ M33.2._____ Polymyositis
- ☐ G61.0 Guillain-Barre Syndrome
- ☐ G70.00 Generalized Myasthenia Gravis, w/o Acute Exacerbation
- ☐ G70.01 Generalized Myasthenia Gravis, w/ Acute Exacerbation
- ☐ D69.3 Immune Thrombocytopenic Purpura

Prescribing Information

IVIG product will be based on supply & availability, unless specified.

Consider baseline assessment of blood viscosity in patients at risk for hyperviscosity, including those with cryoglobulins, fasting chylomicronemia/ markedly high triacylglyccerois (triglycerides), or monoclonal gammopathies.

Consider appropriate lab testing in patients with a higher risk of Hemolysis, including measurement of hemoglobin or hematocrit prior to infusion & within approximately 36 hours and again 7-10 days post infusion.

PRESCRIPTION

Pre-Medications

- ☐ Tylenol 650mg PO
- ☐ Zyrtec 10mg PO
- ☐ Claritin 10mg PO
- ☐ Benadryl 25mg PO
- ☐ Benadryl 25mg IVP
- ☐ Benadryl 50mg PO
- ☐ Benadryl 50mg IVP
- ☐ Pepcid 20mg PO
- ☐ Pepcid 20mg IVP
- ☐ Solu-medrol 125mg IVP
- ☐ Solu-medrol 250mg IVP
- ☐ Solu-medrol 500mg IVP

Other: _____

Pre Labs:

- ☐ CBC
- ☐ CMP
- ☐ CRP
- ☐ ESR
- ☐ Iron Panel
- ☐ Vitamin D
- ☐ Other _____

Immune Globulin IV Infusion

Preferred IVIG: _____

Loading Dose:

☐ IV: Infuse _____gm/kg over _____ days every _____ weeks/ _____months

☐ IV: Infuse _____gm per day over _____ days every _____weeks/ _____months

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Supervising Provider (if applicable) _____

Date: _____ NPI#: _____ Specialty: _____

Practice Name: _____ (If Applicable)

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

Contact Name: _____ Phone: _____ Fax: _____ Email: _____