IVIG ORDER FORM

Phone: 800-783-9655 **Fax: 877-770-4179**

Premier SPECIALTY INFUSION

PATIENT INFORMATION

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

DOB: _____ SSN: _____

Gender: ☐ Male ☐ Female

Emergency Contact: _____

Phone: _____ Relationship: _____

INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available (front and back)

Primary Insurance: _____

Phone: _____ Subscriber: _____

Policy#:_____ Group: _____

Prescription Drug Card: _____

Policy#:_____ Phone: _____

Please Attach

- **Patient demographics, including insurance information**
- **Labs- Antibody testing results, most recent BUN/SCr & IgA level**
- **H&P** ▪ **Medications / therapies tried & failed** ▪ **CSF studies**
- **Nerve Conduction Study results, including velocity**
- **Baseline assessment** ▪ **Biopsy results** ▪ **EMG results**

MEDICAL HISTORY

Height: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____

☐ Cardiac Disease ☐ Diabetic ☐ Renal Dysfunction

STATEMENT OF MEDICAL NECESSITY / PRIMARY DIAGNOSIS

☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
☐ D80.0 Congenital Hypogammaglobulinemia
☐ G62.81 Critical Illness Polyneuropathy (Acute Motor Neuropathy)
☐ M33.90 Dermatopolymyositis
☐ G61.0 Guillian-Barre Syndrome
☐ G61.9 Inflammatory Polyneuropathy, unspecified
☐ G73.3 Lambert-Eaton Myasthenic Syndrome
☐ G61.89 Multifocal Motor Neuropathy (MMN)
☐ G35 Multiple Sclerosis
☐ G70.01 Myasthenia Gravis **with** acute Exacerbation
☐ G70.00 Myasthenia Gravis without Exacerbation
☐ G60.9 Peripheral Neuropathy
☐ M33.20 Polymyositis
☐ G25.82 Stiff-Person Syndrome
☐ Other: _____

PRESCRIPTION AND ORDERS

Is this the first dose? ☐ Yes ☐ No
If No, List product: _____
Date of last infusion: _____ Next Dose Due: _____

Administer Immune Globulin (IVIG):

☐ 2 grams/kg over _____ days, as a loading dose, then _____ grams every _____week(s) for _____ cycles.

☐ ____ mg/kg **or** ____ grams every ____week(s) for ____ cycles.

OTHER ORDERS

Pre-Medication:

☐ Diphenhydramine (Benadryl®) 25mg PO prior to infusion
☐ Acetaminophen (Tylenol®) 650mg PO prior to infusion
Dispense one bottle of #100 each & refill as needed for one year.
☐ Hydration:_____
☐ Other: _____

Flush Orders:

Access: ☐ Peripheral ☐ PICC ☐ Port ☐ Other: _____

☒ Dispense & Flush per PSI Protocol
(NaCl 0.9%, Heparin 10 u/ml, or Heparin 100 u/ml - Qty. QS / Refill: 1 year)

Adverse/Anaphylactic Reaction: Per PSI Protocol

☒ Epinephrine Auto-Injector (EpiPen®) 0.3mg 2-pack - UD
☒ Diphenhydramine 50mg/IV - UD for severe anaphylactic reaction
☒ NaCl 0.9% - 250/500ml - UD for severe anaphylactic reaction
(Dispense one of each with one refill)
✓ Mild reaction give Diphenhydramine 50mg (2 caps), slow IVIG infusion. If needed give 2 additional capsules (50mg).
✓ Moderate reaction give 50mg Diphenhydramine (2caps) and stop IVIG infusion.
✓ Severe reaction w/breathing problem give, 50mg IV Diphenhydramine, EpiPen, 250/500ml NaCl 0.9%, and call 911.

Nursing: Start PIV as required for administration and nurse to administer infusion in home.

PHYSICIAN INFORMATION

Physician: _____

Practice: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

NPI: _____ Contact: _____

Physician Signature: _____**Date**: _____

☐ DAW:_____
(Dispense as Written – Signature Required)

By signing, I certify/verify that the above therapy, products, and services are medically necessary and that this patient is under my care. I have received the necessary authorization to release the above referenced information and medical and/or patient information relating to this therapy.