Intravenous Immunoglobulins (IVIG)

Provider Order Form Rev. 11/16/2023

Please fax completed referral form & all required documents to (833) 786-0025

PATIENT DEMOGRAPHICS

Patient Name: ______________________ DOB: ______________ Phone: ______________

Address: ______________________ City/ST/Zip: ______________________

Allergies: ______________________ ☐ NKDA Weight: ________ ☐ lbs ☐ kg Height: _______ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

Primary Immunodeficiency:

- ☐ Hereditary hypogammaglobulinemia, D80.0
- ☐ Nonfamilial hypogammaglobulinemia, D80.1
- ☐ Selective deficiency of IgG subclasses, D80.3
- ☐ Antibody deficiency with near-normal Ig or with Hyper-Immunoglobulinemia, D80.6
- ☐ CVID with predominant abnormalities of B-cell, D83.0
- ☐ CVID with autoantibodies to B- or T-cells, D83.2
- ☐ Other CVID, D83.8
- ☐ CVID, unspecified, D83.9
- ☐ Other: ______________________, ICD10 __________

Other Diagnoses:

- ☐ Chronic Inflammatory Demyelinating Polyneuropathy, D61.81
- ☐ Guillain-Barre Syndrome, G61.0
- ☐ Multiple Sclerosis, G35
- ☐ Multifocal Motor Neuropathy, G61.82
- ☐ Myasthenia Gravis without (acute) exacerbation, G70.00
- ☐ Myasthenia Gravis with (acute) exacerbation, G70.01
- ☐ Dermatopolymyositis (M33.10-M33.19,M33.90-M33.99), ICD10 __________
- ☐ Polymyositis (M33.20-M33.29), ICD10 __________
- ☐ Other: ______________________, ICD10 __________

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
☐ Asceniv 10% ☐ Bivigam 10% ☐ Gamunex-C 10% ☐ Octagam 5% ☐ Octagam 10% ☐ Panzyga 10% ☐ Other Brand and Concentration: ______________________	Primary Immunodeficiency ☐ **0.4 gm/kg** (______ gm* total) ☐ **0.6 gm/kg** (______ gm* total) ☐ ___ **gm/kg** (______ gm* total)	Primary Immunodeficiency ☐ Infuse IV every _____ weeks x 1 year ☐ OTHER: ______________________
	Other Diagnoses **INDUCTION:** ☐ **2 gm/kg** (______ gm* total) ☐ ___ **gm/kg** (______ gm* total)	Other Diagnoses **INDUCTION:** ☐ Infuse total calculated dose IV divided over _____ days x 1 dose
	MAINTENANCE: ☐ **1 gm/kg** (______ gm* total) ☐ **2 gm/kg** (______ gm* total) ☐ ___ **gm/kg** (______ gm* total) **Specify total calculated dose in grams per infusion and order to the nearest 5 grams.*	**MAINTENANCE:** ☐ Infuse total calculated dose IV every _____ weeks x 1 year ☐ Infuse total calculated dose IV divided over _____ days every ____ weeks x 1 year ☐ OTHER: ______________________

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: ______________________

Date of last treatment: ______________ Date of next treatment: ______________

PRE-MEDICATION ORDERS

- ☐ No premeds ordered at this time
- ☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO
- ☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP
- ☐ Other: ______________________

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

- ☐ No labs ordered at this time ☐ IgG total and subclasses q _________
- ☐ CBC q _________ ☐ CMP q _________ ☐ CRP q _________
- ☐ ESR q _________ ☐ LFTs q _________ ☐ Other: _________

REFERRING PHYSICIAN INFORMATION

Physician Signature: ______________________ Date: ______________

Physician Name: ______________ Provider NPI: ______________ Specialty: ______________

Address: ______________________ City/ST/Zip: ______________

Contact Person: ______________ Phone #: ______________ Fax #: ______________

Email Where Follow Up Documentation Should Be Sent: ______________________

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REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

For Primary Immunodeficiency – documentation prior to initiating any Ig therapy: ***(select all that applies)***

☐ Patient has documented history of recurrent bacterial sinopulmonary infections. *Please attach progress notes.*

- ☐ Required multiple courses or prolonged antibiotic therapy
- ☐ Failure of prophylactic antibiotic therapy
- ☐ Hospitalizations for URI in the past 12 months
- ☐ Other: ______________________________

☐ Patient has documented low pretreatment IgG levels.

Please attach copy of pretreatment serum immunoglobulin results available, including IgG total, IgG subclasses, IgA, and IgM.

☐ Patient has a documented inadequate antibody response to polysaccharide and/or protein antigen(s).

If completed, please attach pre- and post-vaccination titer labs performed prior to initiation of Ig.

If not available, specify reason why antibody challenge was not completed: ______________________________

- ☐ Pneumovax, Date of Vaccination: ____________
- ☐ Prevnar, Date of Vaccination: ____________
- ☐ Tetanus/Diphtheria, Date of Vaccination: ____________
- ☐ Hemophilus, Date of Vaccination: ____________

For continuation of therapy requests:

☐ Patient has shown clinical improvement on therapy (e.g., reduction in frequency and/or severity of infections, decreased hospitalization, reduction in number of missed school or workdays, improved quality of life, etc.)? *Please attach progress notes.*

For Other Diagnoses – documentation of tests conducted prior to initiating Ig therapy:

CIDP

☐ Electromyography (EMG) and Nerve conduction velocity (NCV) tests
☐ Lumbar puncture test
☐ Nerve biopsy report
☐ Neurological Rankin Scale Score

Multifocal Motor Neuropathy

☐ Electromyography (EMG) and Nerve conduction velocity (NCV) tests
☐ anti-GM1 antibodies
☐ Lumbar puncture test

Myasthenia Gravis

☐ Anti-acetylcholine receptor (AChR) antibodies
☐ Baseline MG-Activities of Daily Living (MG-ADL) Evaluation

Dermatopolymyositis and Polymyositis

☐ Electromyography (EMG)
☐ Muscle biopsy report

☐ Other: ______________________________
☐ Other: ______________________________

PRIOR FAILED THERAPIES

Medication Failed: ____________________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ____________________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ____________________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ____________________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ____________________ Dates of Treatment: ______________ Reason for D/C: ______________

Healix Infusion Care · P: (800) 958-4042 · F: (833) 786-0025 · www.HealixInfusion.com