

Intravenous Immunoglobulins (IVIG)

Provider Order Form Rev. 08/2023

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*

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 _____

*ICD 10 Code
Required

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
<input type="checkbox"/> Bivigam 10% <input type="checkbox"/> Gamunex-C 10% <input type="checkbox"/> Octagam 5% <input type="checkbox"/> Octagam 10% <input type="checkbox"/> Panzyga 10% <input type="checkbox"/> Other Brand and Concentration: _____	<u>Primary Immunodeficiency</u> <input type="checkbox"/> 0.4 gm/kg (_____ gm* total) <input type="checkbox"/> 0.6 gm/kg (_____ gm* total) <input type="checkbox"/> _____ gm/kg (_____ gm* total) <u>Other Diagnoses</u> INDUCTION: <input type="checkbox"/> 2 gm/kg (_____ gm* total) <input type="checkbox"/> _____ gm/kg (_____ gm* total) MAINTENANCE: <input type="checkbox"/> 1 gm/kg (_____ gm* total) <input type="checkbox"/> 2 gm/kg (_____ gm* total) <input type="checkbox"/> _____ gm/kg (_____ gm* total) <i>*Specify total calculated dose in grams per infusion and order to the nearest 5 grams.</i>	<u>Primary Immunodeficiency</u> <input type="checkbox"/> Infuse IV every _____ weeks x 1 year <input type="checkbox"/> OTHER: _____ <u>Other Diagnoses</u> INDUCTION: <input type="checkbox"/> Infuse total calculated dose IV divided over _____ days x 1 dose MAINTENANCE: <input type="checkbox"/> Infuse total calculated dose IV every _____ weeks x 1 year <input type="checkbox"/> Infuse total calculated dose IV divided over _____ days every _____ weeks x 1 year <input type="checkbox"/> 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
 - Hospitalizations for URI in the past 12 months
 - Failure of prophylactic antibiotic therapy
 - 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: _____
 - Tetanus/Diphtheria, Date of Vaccination: _____
 - Prevnar, 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: _____