Intravenous Immunoglobulins (IVIG)

Provider Order Form Rev. 08/2026

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

HEALIX INFUSION CARE

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, G61.81
- ☐ Guillain-Barre Syndrome, G61.0
- ☐ Relapsing-Remitting Multiple Sclerosis, G35.A
- ☐ 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

☐ IVIG 10%
☐ IVIG 5%

Healix Infusion Care will select IVIG brand based on payor requirements, product availability, indication, and patient tolerance unless specific brand indicated below.

Specific IVIG Brand Ordered:

_____

DOSE

Primary Immunodeficiency

- ☐ **0.4 gm/kg** (_____ gm* total)
- ☐ **0.6 gm/kg** (_____ gm* total)
- ☐ ___ **gm/kg** (_____ gm* total)

Other Diagnoses

INDUCTION:

- ☐ **2 gm/kg** (_____ gm* total)
- ☐ ___ **gm/kg** (_____ gm* total)

MAINTENANCE:

- ☐ **1 gm/kg** (_____ gm* total)
- ☐ **2 gm/kg** (_____ gm* total)
- ☐ ___ **gm/kg** (_____ gm* total)

DIRECTIONS/DURATION

Primary Immunodeficiency

- ☐ Infuse IV every _____ weeks x 1 year
- ☐ OTHER: _____

Other Diagnoses

INDUCTION:

- ☐ Infuse total calculated dose IV divided over _____ days x 1 dose

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: _____

* Specify total calculated dose in grams per infusion and order to the nearest 5 grams.

If gram dose not specified, dose will be calculated by Healix Infusion Care and rounded to the nearest 5 gram vial size.

Confirm if dose is to be calculated based on: ☐ ***Actual body weight*** ☐ ***Ideal body weight*** ☐ ***Adjusted body weight***

Dose will be adjusted for every +/- 10% change in patient body weight.

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: _____ NPI:_____ TIN:_____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

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Patient Name: _____ DOB: _____

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: _____