Immune Globulin Order Form
(IV infusion)

medix infusion

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<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 Gullain-Barre Syndrome
☐ G70.00 Generalized Myasthenia Gravis, w/o Acute Exacerbation
☐ G70.01 Generalized Myasthenia Gravis, w/Acute Exacerbation
☐ D69.3 Immune Thrombocytopenic Purpura
Other: _____

Prescribing Information

- IVG 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.

***REQUIRED*: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy. INCLUDE AUTH TO RELEASE PHI and/or POA (if applicable). *LAB RESULTS:* Please include brain MRI & CMP/BMP within 3 months.**

PRESCRIPTION*

Pre-Medications

☐ Acetaminophen: 650 mg PO
☐ Diphenhydramine: 25 mg PO
☐ Diphenhydramine: 25 mg IVP
☐ Methylprednisolone: 125 mg SIVP
Other: _____

IMMUNE GLOBULIN (IV Infusion)

Loading Dose (SELECT ONE)

To avoid product waste: Adult dosage is rounded to 5 gm vial
Pediatric Dosage is rounded to the nearest 1 gm vial.
Titrate per Medix Infusion protocol, as patient tolerates.

☐ **IV:** Infuse _____ gm/kg/day for one year
☐ **IV:** Infuse _____ gm per day for one year

Frequency (SELECT ONE)

☐ Once
☐ Daily x _____ doses
☐ Every _____ weeks

Lab Orders

Immunodeficiency Diagnosis: IgG trough to be drawn every 12 weeks at infusion appointment.
Lab: _____ Frequency: _____
Lab: _____ Frequency: _____

Home Infusion Patient Orders Only

Administer by infusion Pump (Ambulatory Infusion Pump, Single or Multiple channels, Electric or Battery operated, with administrative eqipment, worn by patient - E0781). Dispense infusion supplies for external drug infusion pump, per cassette or bag (A4222). Dispense supplies for maintenance of drug infusion catheter, per week (A4221). Per Medix Infusion protocol, an ANA kit which includes 50 mg of Diphenhydramine oral solution will be dispensed to home infusion patients.

Quantity to be Dispensed: _____ grams per month for one year
<<<<PRESCRIBER MUST COMPLETE QUANTITY TO BE DISPENSED & NUMBER OF REFILLS>>>>

Patient: Actual Body Weight+: _____ lbs **or** _____ kg
+ Dose based on actual body weight unless otherwise stated.

Post Treatment Observations: The patient is observed for 30 minutes following the first administration.

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Comments: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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