Immune Globulin Order Form
(IV infusion)

medix infusion

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____

DOB: _____ Phone: _____ Sex: ☐ M ☐ F

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (Required)

☐ _____

ICD 10 Description

☐ _____

Prescribing Information:
IVG product will be based on supply & availability, unless specified

Weight: _____ ☐ lb ☐ kg Height: _____

Patient Status:

☐ New to therapy

☐ Continuing therapy (date of last dose _____)

Allergies: _____

Brand previously used: _____

PRESCRIPTION

Pre-Medications

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

☐ Normal saline hydration to be administered with each infusion
☐ 250 mL @ _____ mL/hr
☐ 500 mL @ _____ mL/hr
☐ 1000 mL @ _____ mL/hr

IMMUNE GLOBULIN (IV infusion)

Dose:

☐ **IV:** Infuse _____ g/kg/day
☐ **IV:** Infuse _____ g/kg/day

Frequency:

☐ Once
☐ Daily x _____ doses
☐ Every _____ weeks for one year
☐ Other: _____

Quantity to be Dispensed: _____ grams per month for one year

Number of Refills: _____

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**

Is yes, please note therapy and last dose: _____

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

Lab Order: _____ **Lab Frequency:** ☐ Every Infusion ☐ Other: _____

Other Orders:

_____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list

Lab Results: Include brain MRI & CMP/BMP within 3 months

Medix Infusion will collect all necessary labs if not included in referral documents

- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindicatoins to conventional therapy
- Include authorization to release PHI and/pr POA if applicable.

PRESCRIBER INFORMATION

Prescriber Name: _____

Signature: _____

NPI #: _____ Date: _____

Supervising Physician (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____