



Immune Globulin® Order Form (IV infusion)

FAX TO: 972.499.9210

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Sex: M F
 Ht: _____ Wt: _____ lbs kg Adjusted Body Weight _____ Primary Language: _____
 (Only use if patient to be dosed per this weight)
 Allergies: _____ Patient Preferred Location: _____

Diagnosis

ICD 10 Code (Required)

ICD 10 Description

Brand previously used: _____

Patient Status

New to therapy
 Continuing therapy (date of last dose _____)

Medication Order

Pre-Medications

Acetaminophen: 650 mg PO
 Diphenhydramine: 25 mg PO
 Diphenhydramine: 25 mg IV
 Methylprednisolone: _____ mg SIVP
 Other: _____

Normal saline hydration to be administered with each infusion
 250 mL over 30 minutes
 500 mL over 30 minutes
 1000 mL over 1 hour

Loading Dose (As applicable)	_____	mg/kg gm/kg grams	x _____ day(s) OR divided over _____ day(s)	One time dose Other: _____ Give maintenance dose _____ weeks after loading dose
Maintenance Dose	_____	mg/kg gm/kg grams	x _____ day(s) OR divided over _____ day(s)	Q _____ weeks x 1 year Other: _____

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

Comments: _____

Required Clinical Documentation

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

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

Lab Results: Include CMP/BMP within 3 months

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

Is the patient on any other disease modifying therapy?

Yes No

If yes, please note therapy and last dose:

Referring Provider Information

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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