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

****Medix Infusion will determine appropriate product based upon benefit investigation****

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 contraindicatoins to conventional therapy**
- **Include authorization to release PHI and/pr POA if applicable.**

Is the patient on any other disease modifying therapy?

☐ Yes ☐ No

If yes, please note therapy and last dose:

_____

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

LAB RESULTS: Include CMP/BMP within 3 months

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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

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