vitalcare
of ROANOKE

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IVIG
INFUSION ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis (ICD-10 below)

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis:

☐ ____ ☐ (ICD-10: _______________)

Pt. Weight ___________ kg Allergies:____

IVIG ORDERS

☐ Gammagard (J1569) ☐ Privigen (J1459)
☐ Gammaplex (J1557) ☐ Carimune__________% (J1566)
☐ Gamunex C (J1561) ☐ Flebogamma (J572)
☐ Bivigam (J1556) ☐ 5% ☐ 10%

IVIG Orders: _________________mg/kg IV divided over ________day(s)
_________________mg/kg IV divided over ________day(s)

Frequency: Every___________weeks or ☐ ___________one time dose

Protocol Pre-Medication Orders: Tylenol 1000mg PO, *please choose one antihistamine:*
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Loratadine 10mg PO

Additional Pre-Medication Orders: ☐ Solu-Medrol _________ mg IVP
☐ NS 0.9% _________ mL IV

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	