



# Immunoglobulin Order Form (IVIG)

Referral Fax: 256-415-6415  
Phone: 256-415-6542  
email: info@mkinfusion.com

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Sex:  M  F Ht: \_\_\_\_\_ Wt: \_\_\_\_\_  lbs  kg  
Primary Language: \_\_\_\_\_ Allergies: \_\_\_\_\_

## <ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

### ICD 10 Code (PROVIDE COMPLETE CODE)

- D69.3 Chronic Immune Thrombocytopenic Purpura
- D80. \_\_\_\_\_ Hypogammaglobulinemia
- D80.9 Primary Humoral Immunodeficiency
- D83. \_\_\_\_\_ Common Variable Immune Deficiency
- G61.0 Guillain-Barré Syndrome
- G61.81 Chronic Inflammatory Demyelinating Polyneuropathy

- G70.00 Generalized Myasthenia Gravis w/o Acute Exacerbation
- G70.01 Generalized Myasthenia Gravis w/Acute Exacerbation
- M33.2 \_\_\_\_\_ Polymyositis
- M33.9 \_\_\_\_\_ Dermatopolymyositis
- Other: \_\_\_\_\_

**REQUIRED:** Demographics & Most Recent: H&P, clinical notes, lab results, imaging, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy

## PRESCRIPTION

### Pre-Medications

- Acetaminophen: 650 mg PO
- Cetirizine 10 mg PO
- Dexamethasone: \_\_\_\_\_ mg IV
- Diphenhydramine: 25 mg PO
- Diphenhydramine: 25 mg IV
- Acetaminophen: \_\_\_\_\_ mg PO
- Famotidine: \_\_\_\_\_ mg IV
- Loratadine 10 mg PO
- Methylprednisolone: \_\_\_\_\_ mg IV
- Ondansetron 4 mg IV

### Lab Orders

- CBC w/diff: every \_\_\_\_\_  weeks  months
- CMP: every \_\_\_\_\_  weeks  months
- IgG trough: \_\_\_\_\_  weeks  months
- Other: \_\_\_\_\_  weeks  months

### Drug

- IV Immunoglobulin  
*\*Montgomery Keeton Infusion Center will determine appropriate product based upon benefit investigation*

OR

- IV Immunoglobulin product \_\_\_\_\_ (DO NOT SUBSTITUTE)

### Dose (SELECT ONE)

- IV: Infuse \_\_\_\_\_ gm/kg
- IV: Infuse \_\_\_\_\_ gm

\*\*To avoid product waste, MKIC will round up adult dosage to the nearest 5 gm vial\*\*

### Frequency (SELECT ONE)

- Once
- Daily x \_\_\_\_\_ doses every \_\_\_\_\_ weeks x 1 year
- Every \_\_\_\_\_ weeks x 1 year

### PRN HYDRATION w/IVIG INFUSION (SELECT ONE)

- IV: infuse 500 mL NS with each treatment x 1 year
- IV: infuse 1000 mL NS with each treatment x 1 year

**Adverse Events:** In the event of an adverse reaction occurring at Montgomery Keeton Infusion Center, MKIC will utilize their adverse reactions protocol

Is the patient on any other disease modifying therapy?  Yes  No  
If yes, please note therapy and last dose: \_\_\_\_\_

## PRESCRIBING INFORMATION

Prescriber Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Date: \_\_\_\_\_ NPI #: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Office phone #: \_\_\_\_\_ Office Fax #: \_\_\_\_\_