(intravenous immunoglobulin)

IVIG infusion orders

Evansville Multi-Specialty Clinic

Patient Name _____ DOB _____

Phone _____ M ☐ F ☐

*DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Primary Immunodeficiency (PI)
- ☐ _____ Idiopathic Thrombocytopenic Purpura (ITP)
- ☐ _____ Multifocal Motor Neuropathy (MMN)
- ☐ _____ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- ☐ _____ Myasthenia Gravis
- ☐ _____ Hypogammaglobulinemia
- ☐ _____ _____ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____ *(other)*
- ☐ Solu-Medrol 125mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ _____ *(other)*

IVIG ORDERS

BRAND

- ☐ Gamunex (10%)
- ☐ Gammagard (10%)
- ☐ Privigen (10%)
- ☐ Flebogamma DIF (10%)
- ☐ Octagam (10%)
- ☐ Gammaked (10%)
- ☐ Gammaplex (10%)
- ☐ Carimune_____ %

DOSAGE

- ☐ _____ gm per day
- ☐ _____ mg/kg over

X ____ days

FREQUENCY

- ☐ every _____ weeks
- ☐ one-time dose/treatment

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

_____

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____

Some diagnosis may be off-label for use with specific IVIG brands, please check with the manufacturer and the patients payer prior to administrator of IVIG