Oregon Specialty Infusion
A Practice of Oregon Specialty Group

Specialty Order Form

Patient:_____	Ordering Provider:_____
DOB:_____ ☐ M ☐ F	NPI:_____
Height:_____ Weight:_____ lbs.	Practice:_____
Allergies:_____	Phone:_____
Diagnosis:_____	Fax:_____
ICD-10 Code(s):_____	Contact Name:_____

Has the patient been treated for this condition previously? ☐ No ☐ Yes, medication(s):_____

Is the patient currently on therapy? ☐ No ☐ Yes, medication(s):_____

☐ **PRIVIGEN** Dose:_____ gm every_____ weeks

Pre-Medication(s):

Tylenol:_____ mg P.O.

Benadryl:_____ mg IVP (May repeat X 1 PRN)

Decadron:_____ mg IVP (May repeat X 1 PRN)

Labs: CBC, CMP to be drawn every_____ weeks

Vital Signs: Every 30 minutes until infusion completed

INFUSION RATE

Initial Infusion Rate (Primary Humoral Immunodeficiency)
0.3 mL/kg/hr and gradually advance to the maximum rate as tolerated

Maintenance Infusion Rate (Primary Humoral Immunodeficiency)
Increase to 4.8 mL/kg/hr (if tolerated)

** Monitor the patient's vital signs throughout the infusion. Slow or stop the infusion if adverse reactions occur. If symptoms subside promptly, the infusion may be resumed at a lower rate that is comfortable for the patient.

Physician's Signature:_____ **Date:**_____