Oregon Specialty Infusion
A Practice of Oregon Specialty Group

Immunoglobulin Order Form (IVIG)

Fax To: 503-540-3105

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

Oregon Specialty Infusion will determine appropriate product based upon benefit investigation

OR

☐ IV Immunoglobulin product ____________________________ (DO NOT SUBSTITUE)

Dose (SELECT ONE)

☐ **IV:** Infuse ________ gm/kg
☐ **IV:** Infuse ________ gm

To avoid product waste, OSI 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 Oregon Specialty Infusion clinic, OSI 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 #: ____