

PATIENT INFORMATION

PATIENT NAME: _____ PHONE: _____

DATE OF BIRTH: _____ SEX: M F HEIGHT: _____ WEIGHT: _____ LBS KG

ALLERGIES: _____ PREFERRED CLINIC: _____

REFERRAL STATUS: NEW REFERRAL ORDER CHANGE ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

***PLEASE COMPLETE ICD-10 FOR SPECIFIC DIAGNOSIS**

<input type="checkbox"/> D69.3 Immune Thrombocytopenic Purpura (ITP)	<input type="checkbox"/> G70.00 Myasthenia Gravis w/o acute exacerbation
<input type="checkbox"/> D80.____ Hypogammaglobulinemia	<input type="checkbox"/> G70.01 Myasthenia Gravis with acute exacerbation
<input type="checkbox"/> D83.____ Common Variable Immune Deficiency	<input type="checkbox"/> M33.2____ Polymyositis
<input type="checkbox"/> G61.0 Guillain Barre Syndrome	<input type="checkbox"/> M33.9____ Dermatopolymyositis
<input type="checkbox"/> G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	
<input type="checkbox"/> ICD-10 CODE: _____ DESCRIPTION: _____	

REQUIRED DOCUMENTATION

Insurance Information List of Medications Most recent History & Physical Recent Labs & IG Levels

MEDICATION ORDER

***Product selection based according to availability & payor guidelines**
 To restrict substitution, indicate required brand here: _____

Intravenous Immune Globulin (IVIG) per protocol

_____ gm/day OR _____ gm/kg/day IV

Single Dose

Daily x _____ days (1 cycle)

Repeat dose/cycle every _____ weeks

OTHER: _____

PRE-MEDICATIONS

PO

Acetaminophen: 650 mg

Cetirizine: 10 mg

Diphenhydramine: 25 mg

IV

Methylprednisolone: 125 mg

Diphenhydramine: 25 mg

OTHER: _____ PO IV

*Dosing rounded 5 gm for adults & 1gm for pediatrics to minimize drug waste

LAB ORDERS

LAB: _____ FREQUENCY: _____

REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 30 minutes following the first infusion.
 In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ NPI #: _____

EMAIL: _____ PHONE: _____ FAX: _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ CONTACT NAME: _____
(IF APPLICABLE)

SIGNATURE: _____ DATE: _____
(NO STAMPS)

SUBSTITUTION PERMITTED | DISPENSE AS WRITTEN