immersiv HEALTH

IVIG ORDER FORM
FAX TO: 855.694.4656

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

- ☐ D69.3 Immune Thrombocytopenic Purpura (ITP)
- ☐ D80._____ Hypogammaglobulinemia
- ☐ D83._____ Common Variable Immune Deficiency
- ☐ G61.0 Guillain Barre Syndrome
- ☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- ☐ G70.00 Myasthenia Gravis w/o acute exacerbation
- ☐ G70.01 Myasthenia Gravis with acute exacerbation
- ☐ M33.2_____ Polymyositis
- ☐ M33.9_____ Dermatopolymyositis

☐ 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:** _____

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

PRE-MEDICATIONS

PO
- ☐ Acetaminophen: 650 mg
- ☐ Cetirizine: 10 mg
- ☐ Diphenhydramine: 25 mg

IV
- ☐ Methylprednisolone: 125 mg
- ☐ Diphenhydramine: 25 mg

☐ **OTHER:** _____ ☐ PO ☐ IV

LAB ORDERS

LAB: _____ FREQUENCY: _____

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 30 minutes following the first infusion. Administer per protocol.
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