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IVIG Infusion Order

Patient name____DOB____________________

Phone number_____________________________________Weight_________________________

Diagnosis ____ ICD 10 Code______________________

______ IVIG (Branding will follow insurance formulary protocols)

______ gm/kg per month given over 2 days or sig as directed

______ Other or additional instructions____

____

Pre Meds given PRN Yes or No (circle one)

____Diphenhydramine 25mg/50mg (circle one) IV/PO ____ Solu-Medrol 40mg/125mg IV (circle one)

____Acetaminophen 650mg PO

Is this a new treatment for this patient______________ or continuing treatment_________________

Prior tried and failed medications____

Contact person_____________________________ Phone_______________ Fax _________________

Name of ordering provider____

Ordering provider signature____ Date _______________

Order valid for one year.

Please fax this information, required tests, last two office notes, and insurance cards to infusion coordinator at 302-613-4697. Infusion coordinator can be reached at 302-483-7053.

Additional forms may be found on our website at ArthritisDE.com.