RED RIVER HEALTH
Ambulatory Infusion Clinic

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Intravenous Immunoglobulin (IVIG) Infusion Orders

Patient Name: DOB: ☐ M ☐ F

☐ NKDA Allergies:

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable):

Ordering Provider: Provider NPI:

Practice Phone: Practice Fax:

Diagnosis *(please provide ICD-10 code)*:

☐ _____ _____
ICD-10 *Diagnosis*

Pre-Medication:

☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ Sodium Chloride 0.9% 500mL IV prior to IVIG infusion
☐ Other: _____

Required Documents:

☑ Patient Demographic Sheet
☑ Clinical/Progress Notes, Labs and Tests supporting primary diagnosis *(please attach)*

IVIG ORDERS:

Dosing: ☐ _____gm/kg -**OR**- _____gm **OVER** _____day(s)
☐ _____mg/kg -**OR**- _____mg **OVER** _____day(s)

Pt. weight: _____
(ensure unit of measure is noted)

Frequency: ☐ every_____ weeks for _____ months
☐ _____ doses

IVIG Products: *(please circle preference)*

Bivigam

☐ Teach and train for **Subcutaneous Immunoglobulin (SCIG)** self-administration at home with:
☐ Cutaguig
☐ Hizentra

** Based on product availability, product recommendations may be provided.*

Red River Health Standing Orders:

☑ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: Date:

**If chosen IVIG therapy is unavailable or unauthorized, Red River Health will reach out to the referring prescriber to discuss alternative treatment options.*