INTRAMED Plus
infusion services

Intravenous Immune Globulin (IVIG)

INFUSION & MEDICAL CENTER

1. _____ _____ _____
Patient Name **DOB** **Patient Phone/Cell #**

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ ICD-10 Code:_____

Allergies:_____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes & labs supporting primary diagnosis
- Previous infusion notes/records (if available/applicable)

Patient
Weight: _____ lbs.
Height:_____ in.

IMMUNE GLOBULIN (IVIG)

4. Drug Order:

IVIG_____ grams or _____ gm/kg IV daily for _____ day(s) or _____ week(s)

Frequency: Every _____weeks for _____cycle(s)

Other Dosing Regimen:_____

❑ Administer as per IG product's package insert / protocol

❑ Other Administration instructions:_____

Preferred Brand ❑ Asceniv ❑ Bivigam ❑ Gammagard ❑ Gamunex-C ❑ Privigen ❑ Other: _____

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

Pre-Medication Orders (check the requested orders): Adjust to patient's needs

❑ Acetaminophen 650 mg PO

❑ Diphenhydramine 25 mg PO ❑ Cetirizine 10 mg PO ❑ Loratadine 10 mg PO

❑ Solumedrol _____ mg IV

❑ Other: _____

❑ None

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION	LOCATIONS
CENTRAL FAX **803.794.0404**	COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 800.767.6337