INTRAMED Plus
infusion services

Intravenous Immune Globulin (IVIG)

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)

Drug Order:

4. **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.

Anaphylaxis kit to be provided per Intramed Policy:
Kit includes Epi 1 mg/ml (1), diphenhydramine 50 mg/mL (2), 0.9% NS 500 mL (1) methylprednisolone 125 mg/2 mL (1)

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 CENTRAL FAX **803.999.1754** ALTERNATE FAX 803.999.1887	**LOCATIONS** COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 800.767.6337