

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.
Patient 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 803.999.1960
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