



Rx Order Form - IVIG

Fax Form to (626) 999-3236

Patient Information		Prescriber Information	
Patient Name: _____		Prescriber Name: _____	
Address: _____		Address: _____	
City, State, Zip: _____		City, State, Zip: _____	
Home Phone: _____		Phone: _____ Fax: _____	
Cell Phone: _____		DEA: _____ NPI #: _____	
DOB: _____ Gender: ☐ M ☐ F		Contact Person: _____	
Weight: _____ lbs.			
Allergies ☐ NKDA ☐ Specify: _____			
Insurance Information (Please fax a copy of the front and back of all cards)			
Primary Insurance: _____		ID#: _____	Group: _____
Secondary Insurance: _____		ID#: _____	Group: _____
Prescription Card: _____	ID#: _____	BIN#: _____	PCN#: _____ Group: _____
Diagnosis (ICD-10) (please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization)			
☐ D69.3 Idiopathic Thrombocytopenic Purpura	☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy	☐ D83.xx Primary Immunodeficiency Syndrome	☐ Other: _____
Premedication			
Premedication can be given 30-60 minutes prior to infusion:			
☐ Acetaminophen PO: ☐ 325mg ☐ 500mg ☐ 650mg			
☐ Diphenhydramine: ☐ 25mg IV ☐ 50mg IV ☐ 25mg PO ☐ 50mg PO, or ☐ Alternate oral antihistamine:			
☐ Cetirizine 10mg ☐ Loratadine 10mg. _____			
☐ Methylprednisolone ☐ 125mg IV ☐ 40mg IV OR ☐ _____mg PO; ☐ Fexofenadine 60mg, or ☐ 180mg			
☐ Others/Miscellaneous: _____			
☐ Epinephrine pen Auto-injector 2 pack 0.3mg/0.3ml IM as needed for anaphylaxis			
IVIG			
Loading Dose IVIG: _____ grams. Frequency _____. For _____.			
Maintenance Dose IVIG: _____ grams. Frequency _____. For _____.			
Grams will be rounded down to nearest vial if at least 90% of calculated dose; otherwise rounded up.			
☐ Prior IVIG treatment and tolerance.			
☐ Ig 0.4g/kg IV daily. Initiate first dose at 15-30 mL/hr and increase rate every 30-60min for duration of infusion.			
For subsequent doses, titrate every 10-30min to a final max rate listed in infusion table.			
☐ Other: _____			
Flushing Protocol:			
☐ NaCl 0.9% 5-10ml IV before and after infusion			
☐ Heparin 10 units/ml 3-5ml IV after infusion for peripheral/PICC access and PRN			
☐ Heparin 100 units/ml 3-5ml IV after infusion for Port IV access and PRN			
☐ All infusion supplies necessary to administer the medication			
*Skilled Nurse to assess, teach, and administer prescribed medication and admit for services.			
By signing below, I certify that the above therapy is medically necessary and Substitution is authorized unless noted otherwise.			
_____ Provider Signature		_____ Date	_____ Notes

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