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 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 ❑ Panzyga ❑ 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**	**INFUSION CENTER LOCATIONS** **BERKELEY CHARLESTON COLUMBIA GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**