Wells Infusion Centers

IVIG ORDER FORM

PLEASE EMAIL COMPLETED FORM AND SUPPORTING DOCUMENTATION TO REFERRALS@WELLSINFUSION.COM. YOU CAN ALSO FAX IT TO 1-570-9INFUSE (1-570-946-3873)

Patient's Name (Last, First, Middle) ________________________________ DOB ______________________

Patient's height in feet and inches ____________________ *Patient's weight in pounds* ________________________

■ Diagnosis

Please provide the diagnosis **and** the most specific ICD-10 code available: ____

■ Details Needed for Approval

- Recent laboratory results including patient's IgG levels. Other disease-specific labs should be included (eg. platelet count with ITP).
- Chart should include history of difficult-to-treat infections, deficiency in producing antibodies in response to vaccination, etc.

■ Premedication Order

Oral medications to be taken by the patient at least 60 minutes prior to start of infusion treatment. May be taken at home:

☐ Acetaminophen _______mg ☐ Diphenhydramine _______mg ☐ Cetirizine _______mg

IV medications to be administered prior to start of the infusion treatment (for infusions only, not for injections):

☐ Dexamethosone _______mg ☐ Famotidine _______mg ☐ Methylprednisolone _______mg
☐ Diphenhydramine _______mg ☐ Metoclopramide _______mg ☐ ______________________

■ Medication Order

☐ Gammagard 10% ☐ Gammaked 10% ☐ Gammaplex 10% ☐ Gamunex 10%

☐ IV ______________ ☐ Octagam 10% ☐ Panzyga 10% ☐ Privigen 10%

Dose: ______ mg/kg

Frequency: To be administered ______________________________ for _____________. (Example: 4 consecutive days per month, for 1 year)

Rate:

☐ ______ ml over ______ minutes
☐ Start at ______ ml/hr, after ______ minutes increase to ______ ml/hr, after ______ minutes increase to ______ ml/hr, after ______ minutes increase to ______ ml/hr, after ______ minutes increase to ______ ml/hr.

Volume:

☐ ______ ml of normal saline ☐ ______ ml of half normal saline ☐ ______ ml of D5W

After the infusion is complete, flush with normal saline. Check vitals and monitor for signs and symptoms of an infusion reaction at start, throughout infusion, and after completion.

■ Rescue Management in case of Infusion Therapy Reaction

Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction. Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed. For severe reactions, administer Epi-pen or equivalent and call 911.

■ Ordering Provider Authorization

Provider Signature: ______________________________ Name: ____________________ Date: _____________________

Address: ____

Phone: __________________ Fax: __________________ Indiv. NPI #: ______________ License: __________________

Best Contact Person in Office: ____________________________ Direct Phone to Contact Person: ________________________

Documentation to Include:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.