Ascension St. Vincent's Southside Infusion Center
Phone: 904-296-5994 Fax: 904-296-9070

Patient Name:_____
Date of Birth:_____
Patient Phone #:_____
Insurance:_____
Subscriber ID:_____

Immune Globulin (IVIG, Asceniv, Bivigam, Flebogamma DIF, Gammaplex, Octagam, Panzyga, Privigen) Order Set

Fill out all information on this form and attach the following as appropriate:
-Copy of prescription/medical card (front and back) -Pertinent labs related to diagnosis and medication administration -Pertinent clinical/progress notes and tests supporting diagnosis.
-Sign, date and fax to: 904-296-9070

General Information

Height	_____ inches	**Weight**	_____ kg	**Allergies**	☐ NKDA	☐ List: _____

Diagnosis	**ICD 10 Code(s)**	**J Code**		**CPT Code**
☐ Primary Immune Deficiency Disease ☐ Secondary Immune Deficiency (SID) ☐ Hypogammaglobulinemia ☐ Myasthenia Gravis ☐ Multifocal Motor Neuropathy ☐ Idiopathic Thrombocytopenic Purpura (ITP) ☐ Guillian-Barré Syndrome (GBS) ☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) ☐ Other: _____	☐ D80.9 ☐ D84.82 ☐ D80.1 ☐ G70.0 ☐ G61.82 ☐ D69.3 ☐ G61.0 ☐ G61.81 ☐ Other: _____	☐ J1459 (Privigen) ☐ J1556 (Bivigam) ☐ J1557 (Gammaplex) ☐ J1561 (Gamunex-C/ GammaKed) ☐ J1566 (IVIG powder, not otherwise specified)	☐ J1568 (Octagam) ☐ J1569 (Gammagard) ☐ J1572 (Flebogamma/ Flebogamma Dif) ☐ J1599 (IVIG liquid, not otherwise specified	☐ CPT Code: _____

Labs (prior to scheduling infusion)

☑ BMP, Serum IgG Levels

Nursing Orders	**Pre-medications (not required)**	
☐ Discharge patient when stable and meets protocol criteria	☐ Acetaminophen 975 mg PO, once	☐ Diphenhydramine 25 mg PO, once
Emergency/Anaphylaxis Order	☐ Cetirizine 10 mg PO, once	☐ Diphenhydramine 25 mg IV, once
☐ Follow standard orders for management of allergies and anaphylaxis reactions	☐ Dexamethasone 20 mg IV, once	☐ Other: _____
	☐ Ondansetron 4 mg IV, once	☐ Other: _____

Medication Orders

Brand (may substitute based on insurance)		**Immune Globulin IV Dose**	**Select Treatment Type**	
☐ Asceniv ☐ Bivigam ☐ Flebogamma DIF ☐ Gammaplex ☐ Gammagard	☐ Gammagard S/D ☐ Gammaked ☐ Gamunex ☐ Octagam ☐ Panzyga ☐ Privigen	☐ 400 mg/kg ☐ 500 mg/kg ☐ 1 g/kg ☐ Other: ____ mg/kg	☐ Once	☐ Every week for ____ dose(s) ☐ Every 3 weeks for ____ dose(s) ☐ Every 4 weeks for ____ dose(s) ☐ Other: _____

Order Comments: *Pharmacy may adjust dose +/- 10% of calculated dose per Pharmacy and Therapeutics Committee approved protocol.
☑ Pharmacy may substitute a biosimilar based on insurance coverage.

Fax infusion records/discharge summary to:		**Date**	____/____/____	**Time**	

MD Print Name		**MD Signature**	