Provider Order Form

IVIG (INTRAVENOUS IMMUNOGLOBULIN)

Uptiv Health

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ Hepatitis B status result

PATIENT

Full Name: DOB:

Mobile Phone: Height: Weight: ☐ lbs ☐ kg

Allergies: ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Primary Immunodeficiency (PI) D83. ___ ☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) G61.81 ☐ Dermatomyositis M33.90

☐ Multifocal Motor Neuropathy G61.82 ☐ Polymyositis G33.20 ☐ Other: _____

PROVIDER

Provider Name: Provider NPI:

Practice Name: Referral Coordinator Name:

Practice Address:

Phone: Fax: Email:

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg
☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg
☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other: _____

THERAPY ADMINISTRATION

Indicate your preferred IVIG product. Uptiv Health will select the product based on payor requirements, product availability, and indication: Dose rounded to the nearest 5 gm.

Medication		**Dose**	**Frequency**
IVIG, Immunoglobulin, IV			
☐ Octagam 10%	☐ Alyglo	Loading Dose: ☐ IVIG____ gm/day x ____days; OR ____ gm/kg/course divided over ____ days	
☐ Octagam 5% (PI only)	☐ Privigen		
☐ Gamunex-C	☐ Gammagard	Maintenance Dose: ☐ IVIG _____ gm/kg/day IV x _____ days every _____weeks.	
☐ Other: _____		☐ IVIG _____ gm/kg IV divided over _____ days every _____weeks.	
		☐ IVIG _____ grams IV x _____ days every _____weeks	

Refills ☐ Zero ☐ 12 months ☐ _____ Order valid for 1 year unless otherwise stated. _____

☒ Flush with 0.9% sodium chloride at infusion completion.

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC	☐ at each dose	☐ every _____
☐ CMP	☐ at each dose	☐ every _____
☐ Other _____	☐ at each dose	☐ every _____

SPECIAL INSTRUCTIONS

Provider Signature Date