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

☐ Cetrizine (Zyrtec) 10 mg PO

☐ Other: _____

THERAPY ADMINISTRATION

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

Medication	Dose	Frequency
☒ IVIG, Immunoglobulin, IV	☐ Loading: ____ gm/day x ____ days; OR ____ gm/kg/course divided over ____ days	
☐ Gamunex-C		
☐ Gammagard	☐ Maintenance: ____ gm/day x ____ days; OR ____ gm/kg/course divided over ____ days	
☐ Octagam	Every ____ weeks.	
☐ Other: _____		

(Include dosage, frequency)

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