



# IVIG

(Gamunex-C, Privilgen, Gammagard)

Outpatient Infusion

## Order Form

<b>Patient Name</b>	
<b>DOB</b>	
<b>Address</b>	
<b>Phone</b>	

**Order Status**       New Order       Renewal       Dose or Frequency Change

<b>Allergies:</b>		<b>Weight:</b>
		<b>Height:</b>
<b>Diagnosis</b>	<input type="checkbox"/> Idiopathic thrombocytopenia purpura <input type="checkbox"/> Chronic inflammatory demyelinating polyneuropathy <input type="checkbox"/> Dermatomyositis <input type="checkbox"/> Other:	<b>Diagnosis Code:</b>

<b>Required Information</b>	CBC and CMP (please include lab result documents)	Date:
	IgG levels	Date:
	Applicable labs:	Date:
<b>Labs</b>	<input type="checkbox"/> CBC, CMP, IgG every:	<input type="checkbox"/> Other:

### Required Documentation

- H&P or progress note supporting diagnosis
- Medication history
- Recent labs (as above) and/or diagnostic test results

### Pre-Medications

- |  |                          |                             |  |                              |
|--|--------------------------|-----------------------------|--|------------------------------|
| <input type="checkbox"/> Diphenhydramine | <input type="radio"/> PO | <input type="radio"/> 25 mg | <input type="checkbox"/> Acetaminophen | <input type="radio"/> 325 mg |
|  | <input type="radio"/> IV | <input type="radio"/> 50 mg |  | <input type="radio"/> 650 mg |
| <input type="checkbox"/> Other:          |                          |                             |  |                              |

### Medication Order

<input type="checkbox"/> <b>Gamunex-C</b>	<input type="checkbox"/> Loading dose:
<input type="checkbox"/> <b>Privilgen</b>	<input type="radio"/> _____ gm/day IV x _____ days every _____ weeks, for _____ months <input type="radio"/> _____ gm/kg IV divided over _____ days every _____ weeks, for _____ months
<input type="checkbox"/> <b>Gammagard 10% Liquid</b>	<input type="checkbox"/> Maintenance dose:
<input type="checkbox"/> <b>Other:</b>	<input type="radio"/> _____ gm/day IV x _____ days every _____ weeks, for _____ months <input type="radio"/> _____ gm/kg IV divided over _____ days every _____ weeks, for _____ months
	<input type="checkbox"/> Other:

Dose will be calculated on adjusted body weight if actual body is > 125% of IBW unless otherwise stated

### Infusion Reaction Medications

Hypersensitivity Reaction Protocol will be utilized unless otherwise specified

Provider (print name):	Date:
Provider Signature:	NPI:
Office Phone:	Office Fax:

# OUTPATIENT INFUSION CENTERS

## Select an Infusion Center below (check box):

- Glendale Infusion Clinic  
6220 W Bell Road, Glendale AZ 85308
- Osborn NSI Infusion Clinic  
7242 E Osborn Road Ste 340, Scottsdale AZ 85251
- Pima Infusion Clinic  
8405 N Pima Center Parkway Ste 201, Scottsdale AZ 85258

## How to Refer:

- Fax the medication order form along with the selected infusion center form and all necessary documentation to central scheduling and call to set up patient information.
  - Central Scheduling Phone: (623) 434-6138
  - Central Scheduling Fax: (602) 331-5765