Fax: 614-929-7199/ Phone: 614-929-3349/ Email: Info@infuseoneohio.com

(intravenous immunoglobulin)

INFUSE ONE

IVIG infusion orders

Patient Name _____ DOB _____

Phone _____ M ☐ F ☐

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Primary Immunodeficiency (PI)
- ☐ _____ Idiopathic Thrombocytopenic Purpura
- ☐ _____ Multifocal Motor Neuropathy (MMN)
- ☐ _____ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- ☐ _____ Myasthenia Gravis
- ☐ _____ Hypogammaglobulinemia
- ☐ _____ _____ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Cetirizine 10mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ _____
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ *(other)*

IVIG ORDERS

BRAND

- ☐ Gamunex (10%)
- ☐ Gammagard (10%)
- ☐ Privigen (10%)
- ☐ Flebogamma DIF (10%)
- ☐ Octagram (10%)
- ☐ Gammaked (10%)
- ☐ Gammaplex (10%)
- ☐ Carimune ____ %

DOSAGE

- ☐ gm per day
- ☐ mg/kg over

X _____ days

FREQUENCY

- ☐ one-time does/treatment
- ☐ every _____ weeks

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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