HONORHEALTH

IVIG

(Gamunex-C, Privigen, Gammagard)

Outpatient Infusion

Order Form

Patient Name	
DOB	
Address	
Phone	

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

Allergies:		**Weight:** **Height:**
Diagnosis	☐ Idiopathic thrombocytopenia purpura ☐ Chronic inflammatory demyelinating polyneuropathy ☐ Dermatomyositis ☐ Other:	**Diagnosis Code:**
Required Information	CBC and CMP (please include lab result documents)	Date:
	IgG levels	Date:
	Applicable labs:	Date:
Labs	☐ CBC, CMP, IgG every:	☐ Other:

Required Documentation

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

Pre-Medications

☐ Diphenhydramine ○ PO ○ IV ○ 25 mg ○ 50 mg ☐ Acetaminophen ○ 325 mg ○ 650 mg

☐ Other:

Medication Order

☐ **Gamunex-C** ☐ **Privigen**	☐ Loading dose: ○ _____ gm/day IV x _____ days every _____ weeks, for _____ months ○ _____ gm/kg IV divided over _____ days every _____ weeks, for _____ months
☐ **Gammagard 10% Liquid** ☐ **Other:**	☐ Maintenance dose: ○ _____ gm/day IV x _____ days every _____ weeks, for _____ months ○ _____ gm/kg IV divided over _____ days every _____ weeks, for _____ months
	☐ 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: