Email: intake@infuseone.com | Phone: 1-800-581-0645 |
Please refer to website www.infuseone.com for location specific fax numbers

(intravenous immunoglobulin)

# IVIG infusion orders

INFUSE ONE

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 ____ %
- Hypvia (10%)

### 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 _____