IVIG

Provider Order Form rev. 1/01/2022

AleraCare
CALIFORNIA
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PATIENT INFORMATION

Patient Name: DOB:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

MEDICATION ORDER

☐ **Gammagard Liquid**	☐ (PI)_____ (ref range 300-600mg/kg) IV every 3-4 weeks ☐ (MMN) _____ gm/day x _____ days; OR _____gm/kg/course divided over _____ days (ref range 0.5- 2.4gm/kg) IV once per month
☐ **Gammaked**	☐ (ITP) _____ gm/day x _____ days; OR _____gm/kg/course divided over _____ days (ref range 2g/kg) ☐ (CIDP) Loading dose-_____gm/day x _____ days; OR _____gm/kg/course divided over _____ days (ref range loading dose 2g/kg) ☐ (CIDP) Maintenance _____gm/day x _____ days; OR _____gm/kg/course divided over _____ days (ref range 1g/kg every 3 weeks) ☐ (PI) _____mg/kg (ref range 300-600mg/kg) every 3-4 weeks
☐ **Octagam**	☐ 5% (PI) _____mg/kg (ref range300-600 mg/kg) IV every 3-4 weeks ☐ 10% (Chronic ITP) 1 g/kg daily for 2 consecutive days (Administer Octagam 10% at a total dose of 2 g/kg, divided into two doses of 1 g/kg (10 Ml/kg) given on two consecutive days.)
☐ **Asceniv**	☐ (PI) _____mg/kg (ref range 300-800mg/kg) IV every 3-4 weeks
☐ **Bivigam**	☐ (PI) _____mg/kg (ref range 300-800mg/kg) IV every 3-4 weeks
☐ **Gammagard S-D**	☐ (PI) _____mg/kg (ref range 100-400mg/kg) IV once monthly ☐ (ITP) 1g/kg. Up to three separate doses may be given on alternate days

☐ If product unavailable, a different therapy listed above may be administered.
☐ If product unavailable, contact provider to discuss therapy options.
☑ Flush with 5% dextrose in water (D5W) at completion of infusion

☐ Patient is required to stay for 30-minute observation post infusion
☐ Patient is NOT required to stay for observation time
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

ICD-10 CODE

☐ D69.3 Immune thrombocytopenic purpura
☐ D80 Immunodeficiency with predominantly antibody defects
☐ D81 Combined immunodeficiencies
☐ D82 Immunodeficiency associated with other major defects
☐ D83 Common variable immunodeficiency
☐ G11.3 Cerebellar ataxia with defective DNA repair
☐ G61.81 Chronic inflammatory demyelinating polyneuritis

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature**

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication ☐ History and Physical Report
☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months