

# Intravenous Immunoglobulin 10% (IVIG 10%)

Provider Order Form rev. 1/25/26



- Saint Cloud, FL
- Lake Mary-Sanford, FL
- Nashville, TN
- Gallatin, TN

## PATIENT INFORMATION

Referral Status:  New Referral  Updated Order  Order Renewal

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

ICD-10 code (required): \_\_\_\_\_ ICD-10 description: \_\_\_\_\_

NKDA Allergies: \_\_\_\_\_ Weight (lbs/kg): \_\_\_\_\_ Height: \_\_\_\_\_

Patient Status:  New to Therapy  Continuing Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

## PROVIDER INFORMATION

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## NURSING

- Providenursing care per IVCARE INFUSION Nursing Procedures, including reaction management and post-procedure

## PRE-MEDICATION ORDERS

- acetaminophen (Tylenol)  500mg /  650mg /  1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl)  25mg /  50mg  PO /  IV
- methylprednisolone (Solu-Medrol)  40mg /  125mg IV
- hydrocortisone (Solu-Cortef)  100mg IV
- Other: \_\_\_\_\_
- Dose: \_\_\_\_\_ Route: \_\_\_\_\_
- Frequency: \_\_\_\_\_

## LABORATORY ORDERS

- CBC  at each dose  every \_\_\_\_\_
- CMP  at each dose  every \_\_\_\_\_
- Other: \_\_\_\_\_

## THERAPY ADMINISTRATION

IVCARE will select the product based on payor requirements, product availability, and indication: Gammagard Liquid, Gammagard SD, Gammaked, Gamunex-C, Hizentra, Octogram, Privigen, Flebogamma, Hyguia, Panzyga, Bivigam, and Cuvitru.

Choose an Indication below.

- Primary Immunodeficiency (PI)** \_\_\_\_\_ mg/kg (ref range 100-800mgmg/kg every 3-4 weeks)

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- Chronic Inflammatory demyelinating polyneuropathy (CIDP)** Loading: \_\_\_\_\_ gm/day x \_\_\_\_\_ days; OR \_\_\_\_\_ gm/kg/course divided over \_\_\_\_\_ days (ref range 2g/kg) Maintenance: \_\_\_\_\_ gm/day x \_\_\_\_\_ days; OR \_\_\_\_\_ gm/kg/course divided over \_\_\_\_\_ days (ref range 1g/kg every 3 wks)

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- Multifocal motor neuropathy (MMN)** \_\_\_\_\_ gm/day x \_\_\_\_\_ days; OR \_\_\_\_\_ gm/kg/course divided over \_\_\_\_\_ days (ref range 0.5- 2.4gm/kg)

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- Idiopathic thrombocytopenia purpura (ITP)** 1g/kg. Up to three separate doses may be given on alternate days

**OTHER** \*WRITE INSTRUCTIONS HERE

\*Include dosage, frequency and any other special instructions

- Flush with 5% dextrose in water (D5W) at completion of infusion
  - Patient is required to stay for 30-minute observation
- REFILLS:**  Zero /  for 12 months /  \_\_\_\_\_  
(if not indicated order will expire one year from date signed)

Provider Name (Print) \_\_\_\_\_ Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

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