

(intravenous immunoglobulin)



IVIG infusion orders

Patient Name

DOB

Phone

M

F

***DIAGNOSIS** *Please provide ICD-10 code*

Primary Immunodeficiency (PI)

Myasthenia Gravis

Idiopathic Thrombocytopenic Purpura (ITP)

Hypogammaglobulinemia

Multifocal Motor Neuropathy (MMN)

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

(other)

PRE-MEDICATION

Tylenol 1000mg PO

Solu-Medrol 125mg IVP

Diphenhydramine 25mg PO

Diphenhydramine 25mg IVP

Cetirizine 10mg PO

Solu-Cortef 100mg IVP

(other)

(other)

IVIG ORDERS

BRAND			
Gamunex (10%)	Privigen (10%)	Octagam (10%)	Gammaflex (10%)
Gammagard (10%)	Flebogamma DIF (10%)	Gammaked (10%)	Carimune %
DOSAGE			
gm per day	X	days	
mg/kg over			
FREQUENCY		PATIENT WEIGHT	
every	weeks	lbs.	
one-time dose/treatment		kg	

NOTES

ORDERING PROVIDER

Signature X_____

Date

Provider

Phone

Fax