ONE CARE
infusion pharmacy

IVIG ORDER FORM

Local Infusion will select the product based on payor requirements, product availability and indication: Asceniv Bivigam Gammagard Liquid 10% Gammaked 10% Gamunex-C 10% Octagam 5% Octagam 10% Privigen Panzyga[i]

DO NOT SUBSTITUTE. Administer brand:

Patient Name:		DOB:
Mobile Number	Patient Weight: kg	Patient height: In
Allergies		

PROVIDER INFORMATION

Provider Name		Provider NPI:
Signature:		Date:
Contact Name:	Phone:	Fax:

Prerequisites to treatment — ensure the following information is complete and attached with referral:

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

DIAGNOSIS (Provider must specify)

☐ Chronic Inflammatory Demyelinating Polyneuropathy, ICD 10: ☐ Primary Immunodeficiency, ICD 10:

☐ Myasthenia Gravis, ICD 10: ☐ Other:

PRE-MEDICATION

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Cetirizine 10 mg PO

☐ Methylprednisolone (Soil-I-Medrol) 125mg IV ☐ Benadryl 25mg PO

☐ Other: Dose: Route:

Medication

☐ IV ☐ SubQ Active infusions will identify clinically appropriate brand/infusion rates. May substitute based on patient's insurance and product availability.

Loading Dose (as applicable)		☐ mg/kg ☐ gm/kg ☐ grams	x _____day(s) OR divided over _____days(s)	☐ One time dose ☐ Other: _____ *Give maintenance dose days after loading dose*
Maintenance Dose		☐ mg/kg ☐ gm/kg ☐ grams	x _____day(s) OR divided over _____days(s)	☐ Every _____weeks x 1 year ☐Other: _____

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable):

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified
Please fax your order to one of the following locations.

One Care Infusion Pharmacy
2025 Chicago Ave, STE A3
Riverside, CA 92507
Ph: 951-900-1120
Fax: 951-900-1125

One Care Infusion Pharmacy
907 W Coal Ave
Gallup, NM 87301
Ph: 505-726-4155
Fax: 505-726-4304