

IVIG® (intravenous immunoglobulin)

Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____
 DOB: _____ Allergies: NKDA _____
 Phone Number: _____
 Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

Required Documentation

Patient Demographics and Insurance Card Medication List Nerve conduction study, EMG, and nerve conduction velocity (NCV) results (only for CIDP/GBS)
 Clinical/Progress Notes Supporting Dx Recent IG levels

Primary Diagnosis

 ICD-10 Code (required): _____
 Primary humoral immunodeficiency (PI) Dermatomyositis
 Multifocal motor neuropathy (MMN) Idiopathic thrombocytopenic purpura (ITP)
 Chronic inflammatory demyelinating polyneuropathy (CIDP) Other: _____

Pre-Medication

Per violet health protocol: No recommended standard pre-medications for intravenous immunoglobulin
 Other: _____
 Acetaminophen (Tylenol) PO 500mg 650mg 1000mg
 Diphenhydramine (Benadryl) 25mg 50mg PO IV
 Methylprednisolone (Solu-Medrol) IV 40mg 125mg
 Cetrizine (Zyrtec) 10 mg PO

Therapy Administration

DOSING:

Weight based:

IVIG, intravenous immunoglobulin _____ gm/kg IV
 frequency: _____

Flat dose:

IVIG, intravenous immunoglobulin _____ gm IV
 frequency: _____

Other: _____

BRAND:

 May substitute brand based on product availability, payor requirements, and indication

DO NOT SUBSTITUTE. Administer Brand: _____

ROUNDING:

If needed, round dose to to nearest 5 gm vial

REFILL:

x 1 year Other: _____

 Order valid for one year unless otherwise stated

Nursing Orders

- RN to flush and lock VAD/CVAD per violet health protocol (see violetinfusions.com/protocol for policy)
 Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy)
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration.
 RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines.
 Other: Please fax alternative reaction orders, flush orders, or nursing administration orders if checking this box

Lab Orders

CBC at each dose every _____ CRP at each dose every _____
 CMP at each dose every _____ Other: _____

Provider Information

Provider Name: _____ Office Contact Person: _____
 Referring Practice Name: _____ Phone Number: _____
 Referring Practice Address: _____ Fax Number: _____
 City, State, Zip: _____ Email: _____
 Provider NPI: _____
 Provider Signature: _____ Date: _____