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IVIG (Intravenous Immunoglobulin) Infusion Order

_____ **PANZYGA** _____ **OCTAGAM**

Patient Name _____ DOB _____

Phone _____ Patient Weight _____ Height _____

***Please attach demographics, clinic notes and labs (Hep B, Qgold or chest X-ray).**

DIAGNOSIS (Please provide ICD-10 code):

____ PI Immunodeficiency ____ Idiopathic Thrombocytopenic Purpura ____ CIDP

____ MMN Neuropathy ____ Myasthenia Gravis ____ Hypogammaglobulinemia

____ _____

PRE-MEDICATION (If needed):

_____ _____ mg/kg IV (weight based)

_____ Tylenol 1,000 mg PO _____ Solu-Cortef 100 mg IVP

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN _____ _____

ORDERS/DOSAGE:

_____ One time dosage/treatment _____ Every ____ weeks

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____