



(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

Hypogammaglobulinemia

Multifocal Motor Neuropathy (MMN)

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

(other)

PRE-MEDICATION

Tylenol 1000mg PO

Cetirizine 10mg PO

Diphenhydramine 25mg PO

Solu-Medrol 125mg IVP

Solu-Cortef 100mg IVP

Diphenhydramine 25mg IVP

IVIg ORDERS

(other)

BRAND

Gamunex (10%)

Privigen (10%)

Octagram (10%)

Gammaplex (10%)

Gammagard (10%)

Flebogamma DIF (10%)

Gammaked (10%)

Carimune %

DOSAGE

gm per day

X

days

mg/kg over

FREQUENCY

one-time does/treatment

every

weeks

PATIENT WEIGHT

lbs.

kg

NOTES

ORDERING PROVIDER

Signature X

Date

Provider

Phone

Fax