

Gammagard Liquid 10% (IVIG) ORDER FORM

Prerequisites to treatment – ensure the following information is complete and attached with referral: Demographics Prior Authorization Office/Progress Notes

PATIENT INFORMATION

Patient Name: _____ D.O.B. _____ Male Female
 Phone Number: _____ Allergies: _____

DIAGNOSIS

Primary Immunodeficiency ICD 10: _____
 Myasthenia Gravis ICD 10: _____
 Other: _____ ICD 10: _____

PRE-MEDICATION

Tylenol 1000mg PO Solu-Medrol 40mg IVP
 Cetirizine 10mg PO Solu-Medrol 125mg IVP
 Diphenhydramine 25mg PO Other: _____

IV FLUID BOLUS PRIOR TO GAMMAGARD (IVIG):

0.9% NaCL 250mL over _____ minutes OR 0.9% NaCL 500mL over _____ minutes
 Other: _____

MEDICATION

Gammagard liquid 10%

Dosing: IV _____ grams (*Dose will be rounded up to the nearest 5-gram vial size).
 Administer as single day infusion OR Divide dose over _____ days

Duration: Initiate rate at 0.5ml/kg/hr for 30 minutes, if tolerated can gradually increase rate every 30 minutes up to 5ml/kg/hr (per protocol)

Frequency: Every _____ weeks OR Every _____ months

Route: Peripheral IV per protocol PICC capping per protocol PORT capping per protocol

Check vital signs with every rate change

Other: _____

New Start Continuation of Therapy Date of Last Dose (if applicable) _____

REFERRING PROVIDER INFORMATION

For questions regarding patient's care during the infusion, please contact:

Facility: _____ Fax: _____

Name 1st Point of Contact (must be available during infusion): _____

Phone: _____

Name 2nd Point of Contact (must be available during infusion): _____

Phone: _____

By referring to the Medical Associates Infusion Clinic, it is recognized and agreed upon that the referring specialist or delegate listed above will be available and responsive during the duration of the scheduled infusion appointment. This contact should be available to answer any questions and/or address concerns related to the care of the patient. The on-site provider within the Infusion Clinic will be responsible for urgent patient care needs during the infusion.

Ordering Provider Name (please print): _____

Ordering Provider Signature: _____ Date: _____

FAX NUMBER: 563-584-4232

PHONE NUMBER: 563-584-4370

Order valid for 1 year from date of signature unless otherwise specified.