

IV League IVIG Order Form

Patient Information

Patient Name:	Date of Birth:	
Patient Address:	Phone Number:	
Allergies:	Emergency Contact Name & Phone Number:	
IV Access:	Height (inches):	Weight (lbs):
Diagnosis:	ICD-10:	
Date Medication is Needed: <input type="checkbox"/> ASAP <input type="checkbox"/> Other, please specify: _____	Has patient previously received IVIG? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify brand & date: _____	
IV League Nursing Services Requested? <input type="checkbox"/> Yes <input type="checkbox"/> No, please specify home health: _____	Phone: _____	

Prescription Information

PREMEDICATION	<input type="checkbox"/> Acetaminophen 650 mg PO 30 minutes prior <input type="checkbox"/> Diphenhydramine 30 minutes prior, please specify: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> IV Push <input type="checkbox"/> PO <input type="checkbox"/> None <input type="checkbox"/> Other: _____
SUPPORTIVE CARE	<input type="checkbox"/> Acetaminophen 650 mg PO q6h prn <input type="checkbox"/> Diphenhydramine prn, please specify: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> IV Push <input type="checkbox"/> PO <input type="checkbox"/> Hydrocortisone 50 mg IV push prn
LABS	<input type="checkbox"/> CBC w/ diff <input type="checkbox"/> CMP <input type="checkbox"/> CRP <input type="checkbox"/> IgG every _____ weeks <input type="checkbox"/> Other: _____
BRAND	<input type="checkbox"/> IVIG (Brand will be selected by pharmacy, unless specified) <input type="checkbox"/> Specific brand (if medically necessary): _____
DOSE	_____ g/kg OR _____ grams (total dose), pharmacy will round to nearest vial size & use actual or adjusted body weight as clinically indicated
FREQUENCY	Administer IV daily for _____ days, repeat every _____ weeks
INFUSION RATE	<input type="checkbox"/> Pharmacy to determine per manufacturer's guidelines <input type="checkbox"/> Infuse at 40ml/hr for 30 min, 80ml/hr for 30 min, 160ml/hr for 30 min, then 300ml/hr (if indicated)
DURATION	Continue for 1 year unless otherwise specified: _____
ADDITIONAL INSTRUCTIONS	_____

Pharmacy protocol includes the following standard orders: Adverse Reactions: Anaphylaxis kit to be used as needed for reaction per pharmacy protocol. IV Maintenance: Line maintenance and flushing will be provided per pharmacy protocol. Skilled nursing visit to establish venous access, administer medication and assess general status & response to therapy.

Prescriber Information

Prescriber Name:	Phone:	Fax:
Prescriber Address:		
NPI:	DEA:	License:
Prescriber Signature:		Date:

Please fax completed form, patient facesheet, insurance information, progress notes & recent IgG labs

IV League Inc, 6076 Bristol Parkway, Suite 104, Culver City, CA 90230

Phone: 310-645-1500 Fax: 310-645-6464 Email: csr@ivleagueinc.com

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