(intravenous immunoglobulin)

IVIG
infusion orders

Fax completed form to 973-597-0910
or
If you have any questions call 973-597-0900

LSG INFUSION SERVICES
WE INFUSE, YOU RELAX

Patient Name _____ DOB _____

Phone _____ M ○ F ○

*DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Primary Immunodeficiency (PI)
- ☐ _____ Idiopathic Thrombocytopenic Purpura (ITP)
- ☐ _____ Multifocal Motor Neuropathy (MMN)
- ☐ _____ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- ☐ _____ Myasthenia Gravis
- ☐ _____ Hypogammaglobulinemia
- ☐ _____ _____ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg
- ☐ _____ *(other)*
- ☐ _____ *(other)*
- ☐ Solu-Medrol 125mg IVP
- ☐ Diphenhydramine 25mg I
- ☐ _____ *(other)*
- ☐ _____ *(other)*

IVIG ORDERS

BRAND

○ Octagam (10%)

DOSAGE

○ _____ gm per
○ _____ dose gm/kg

X ___ days

FREQUENCY

○ every _____ weeks
○ one-time dose/treatment

PATIENT WEIGHT

_____ lbs.
_____ kg

HEIGHT

_____

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ NPI # _____

Phone _____ Fax _____ EMAIL _____

Some diagnosis may be off-label for IVIG , please check with the manufacturer and the patients payer prior to administrator of IVIG