(intravenous immunoglobulin)

IVIG infusion orders

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 PO

Cetirizine 10mg PO

(other)

Solu-Medrol 125mg IVP

Diphenhydramine 25mg IVP

Solu-Cortef 100mg IVP

(other)

IVIG ORDERS

BRAND

Gamunex (10%) Privigen (10%) Octagam (10%) Carimune %

Gammagard (10%) Flebogamma DIF (10%) Gammaked(10%)

DOSAGE

gm per day

mg/kg over X days

FREQUENCY

every weeks

one-time dose/treatment

PATIENT WEIGHT

lbs.

kg

NOTES

ORDERING PROVIDER

Signature **X**____ Date

Provider Phone Fax

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