vitalcare INFUSION SERVICES of SIOUX FALLS

1020 S Cliff Ave., Sioux Falls, SD 57104
P / 605-220-7824 · F / 605-220-7980
www.vitalcaresiouxfalls.com

IVIG
INFUSION ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis (ICD-10 below)

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis:

☐ _____ ☐ (ICD-10: _____)

Pt. Weight _____ kg Allergies:_____

IVIG ORDERS

☐ Gammagard (J1569)
☐ Gammaplex (J1557)
☐ Gamunex C (J1561)
☐ Bivigam (J1556)
☐ Privigen (J1459)
☐ Carimune_____% (J1566)
☐ Flebogamma (J572)
☐ 5% ☐ 10%

IVIG Orders: _____mg/kg IV divided over _____day(s)
_____mg/kg IV divided over _____day(s)

Frequency: Every_____weeks or ☐ _____one time dose

Protocol Pre-Medication Orders: Tylenol 1000mg PO, *please choose one antihistamine:*
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Loratadine 10mg PO

Additional Pre-Medication Orders: ☐ Solu-Medrol _____ mg IVP
☐ NS 0.9% _____ mL IV

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	