TEXASINFUSION

1935 W. State Street STE 103
Garland, TX 75042
Ph: 972-372-9787
Fx: 972-787-1492

IVIG INFUSION ORDER FORM

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Weight: _____kg; Height: _____in

DIAGNOSIS AND ICD 10 CODE			
☐ CIDP	ICD 10 Code: _____	☐ Multiple Sclerosis	ICD 10 Code: _____
☐ Guillain-Barre syndrome	ICD 10 Code: _____	☐ MMN	ICD 10 Code: _____
☐ Myasthenia Gravis	ICD 10 Code: _____	☐ Other_____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics and Insurance Card	☐ Labs and EDX to supporting primary diagnosis
☐ IgG level and subclass test results, when applicable	☐ First Dose -or- ☐ **Last given dose:_____**
List Tried & Failed Therapies, including duration of treatment: 1) 2) 3)	PA Guidance: CIDP- sensory impairment of more than one limb for at least 2 months. EDX finding showing motor distal latency, motor conduction velocity, prolongation or absence of F-waves. Max 2gm/kg/mo; GBS- Requiring aid to walk, onset of Sx within last four weeks, Max dose: 2gm/kg/mo x 3 months. MG/MS/MMS- contact pharmacy for info.

ORDERS		
Dosing	☐ IVIG 1gm/kg IV every _____weeks ☐ IVIG 2gm/kg IV every _____weeks ☐ Other_____ ☐ NaCl 0.9% _____ml IV ☐ Pre and/or ☐Post IVIG	☐ Tylenol 650mg PO ☐ Benadryl 50mg route _____ (PO or IV) ☐ Other_____
Nursing order	1. RN to start, pause, or discontinue peripheral or central venus access device as needed 2. Flush IV line with 10-20ml saline before and after each medication dose or as needed 3. Flush PORT or Central Line with 500u/5ml Heparin as FINAL flush or as needed 4. Dispense DME pump with all necessary supplies for home infusion	
Anaphylaxis kit per pharmacy protocol (IM .3mg Epinephrine, IV 50mg Diphenhydramine, and IV 500mL 0.9% NS)		
Refills:	☐ X 1 year ☐ _____ doses	

PRESCRIBER INFORMATION		
Prescriber Name:		NPI #:
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

By signing, I authorize Texas Infusion to act as an agent to initiate and execute the insurance authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time in writing via email to pharmacy@texasinfusion.com

PLEASE FAX SIGNED FORM TO 972-787-1492

UPDATED: 1-2-2023