



TEXAS INFUSION

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: | Height: _____ inches; Weight _____ kg |

DIAGNOSIS AND ICD 10 CODE

| | | | |
|--|--------------------|---|--------------------|
| <input type="checkbox"/> Immunodeficiency w/ antibody subclass | ICD 10 Code: _____ | <input type="checkbox"/> Combined ID | ICD 10 Code: _____ |
| <input type="checkbox"/> Severe Combined ID | ICD 10 Code: _____ | <input type="checkbox"/> Common Variable ID | ICD 10 Code: _____ |
| | | <input type="checkbox"/> Other _____ | ICD 10 Code: _____ |

REQUIRED DOCUMENTATION

| | |
|--|---|
| <input type="checkbox"/> This signed order form by the provider | <input type="checkbox"/> IgG level and Ig subclass lab results |
| <input type="checkbox"/> Patient demographics and Insurance Card | <input type="checkbox"/> First Dose to begin by _____ |
| <input type="checkbox"/> Clinical/Progress notes w/ documented infections | <input type="checkbox"/> Last given dose: _____ |

List Tried & Failed Therapies, including duration of treatment:

- 1)
- 2)
- 3)

PA Guidance: Diagnosis of primary immunodeficiency w/ clinically significant functional humoral deficiency. Documented failure to produce antibodies to specific antigens OR a history of **significant** recurrent infections. NOTE: IVIG may NOT be approved for Isolated IgA; IgE; IgM; IgG4 deficiency.

ORDERS

| | |
|--|---|
| Dosing | <input type="checkbox"/> IVIG ___mg/kg IV every ___weeks <input type="checkbox"/> SCIG ___mg/kg IV every ___weeks <input type="checkbox"/> Emla cream- topically 30 min prior <input type="checkbox"/> NaCl 0.9% _____ml IV <input type="checkbox"/> Pre and/or <input type="checkbox"/> Post IVIG <input type="checkbox"/> Tylenol 650mg PO 30 min prior to infusion <input type="checkbox"/> Benadryl 50mg <input type="checkbox"/> PO <input type="checkbox"/> IVP 30 min prior <input type="checkbox"/> Other _____ |
| Infusion orders | 1. RN to start, pause, or discontinue peripheral or central venous 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: | <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses |

PRESCRIBER INFORMATION

| | |
|-----------------------|-------------|
| Prescriber Name: | NPI #: |
| Office Phone: | Office Fax: |
| Office Email: | Date: |
| Prescriber Signature: | |

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