Fax: 832-895-4040
Phone: 832-895-5000
E-mail: intake@adaptivinfusion.com

adaptIV infusion

IVIG (Intravenous Immunoglobulin 10%)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one):* ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one):* ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg | ☐ 650mg | ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg | ☐ 50mg | ☐ PO | ☐ IV
☐ famotidine (Pepcid) 20mg PO
☐ methylprednisolone (Solu-Medrol) ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

Immune Globulin: ☐ No preference ☐ Preferred product: _____

Choose an Indication below.

☐ Primary Immunodeficiency (PI) _____ mg/kg (ref range 100-800mgmg/kg every 3-4 weeks

☐ Chronic Inflammatory demyelinating polyneuropathy (CIDP)
Loading: _____ gm/day x _____ days; OR _____ gm/kg/course divided over _____ days (ref range 2g/kg)
Maintenance: _____ gm/day x _____ days; OR _____ gm/kg/course divided over _____ days (ref range 1g/kg every 3 wks)

☐ Multifocal motor neuropathy (MMN)
_____ gm/day x _____ days; OR _____ gm/kg/course divided over _____ days (ref range 0.5- 2.4gm/kg)

☐ Idiopathic thrombocytopenia purpura (ITP)
1g/kg. Up to three separate doses may be given on alternate days

☐ OTHER
*Include dosage, frequency and any other special instructions

☐ Flush with 5% dextrose in water (D5W) at completion of infusion ☐ Patient required to stay for 60-min observation post infusion
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____ (if not indicated order will expire one year from date signed)

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

_____ _____ _____
Provider Name (Print) *Provider Signature* *Date*

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK