Troy Infusion Center
600 W Main Street
Suite 120
Troy, OH 45373
Phone: 937-401-6620
Fax: 937-401-6629

Washington Township Infusion Center
1989 Miamisburg-Centerville Road
Suite 101
Dayton, OH, 45459
Phone: 937-401-6620
Fax: 937-401-6629

IVIG Order Form

Epic Referral: REF115230

Patient Name: ____________________________________ **DOB:** ___________________

Address: ____

Phone: ______________________ **ICD-10 Diagnosis:** ________________________

IVIG Brand (Required):

☐ Gammagard ☐ Gamunex-C ☐ Privigen

Note – Due to stock changing frequently, requested brand may not be available. We will call you to determine which brand we should use in place.

Loading Dosing: ☐ 0.4g/kg IV daily for _____ days ☐ _____ grams daily for _____ days

Maintenance Dosing: ☐ 0.4g/kg IV ☐ _____ grams ☐ Other________

Frequency: ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Other__________________

Rate: ☐ Standard Rate ☐ Specific Rate____________

Standard rate is 0.5 mg/kg/minute increasing every 15-30 minutes as tolerated.

Order good for: ☐ 6 months ☐ 1-year Other duration: ________________________

Pre-meds: (given at each infusion)

☐ Tylenol 650 mg po or ☐ Tylenol 1000 mg po

☐ Benadryl ____ mg po or ☐ Benadryl _____ mg IV

☐ Solumedrol ____ mg IV

☐ 500 mL 0.9% NaCl IV over 30 minutes

☐ no pre-meds

☐ Other: ____

Port/PICC care per protocol will be performed if applicable including heparin flush (500 units/5mL) and cathflo (2 mg) PRN for patients with a port

Labs (include frequency): ____

Other Comments: ____

Prescriber Printed Name:____

Prescriber Full Address: ____

Office Phone Number: ______________________ **Office Fax Number:** _____________________

Prescriber Signature: ______________________________________ **Date:** ________________