Intravenous Immunoglobulin (IVIG)

Provider Order Form rev. 7/30/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Primary Humoral Immunodeficiency: Idiopathic thrombocytopenia Purpura:

Chronic Inflammatory Demyelinating Polyneuropathy: Multifocal Motor Neuropathy:

Other: Dermatomyositis:

THERAPY ADMINISTRATION *(Select one)*

☐ Gamunex C ☐ Gammagard Liq. ☐ Privigen
☐ Octagam 5% ☐ Octagam 10% ☐ Panzyga
☐ Asceniv *(Please note, to be covered for this therapy, pt must have failed multiple preferred products)*

DOSING

Loading: _____ g/kg=_____(dose) IV over _____ Day(s)
Maintenance: _____ g/kg_____(dose) IV over _____ Day(s)
☐ Brand name checked above medically necessary

MAINTENANCE DOSE FREQUENCY *(Choose one)*

☐ Every _____ weeks
☐ Every _____ months
☐ Once
☐ Other: _____

ADDITIONAL ORDERS

☐ Ok to leave IV to saline lock for tx on consecutive days

LABORATORY ORDERS

☐ CBC w/ diff ☐ at each dose ☐ every: _____
☐ CMP ☐ at each dose ☐ every: _____
☐ Other: _____

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO
☐ Loratadine 10mg PO
☐ Pepcid 20mg ☐ PO / ☐ IVP
☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP
☐ Solumedrol ☐ 40mg / ☐ 125mg IVP
☐ Other: _____

NURSING

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation
☑ Monitor vital signs every 30 minutes and with each rate change.
☑ Administration guidelines vary by IVIG product and brand. Review manufacturer instructions for infusion rate, titration schedule, and filtration requirements.

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications.
Required Labs: Immunoglobulin levels, Renal function, CRP/ESR, ANA,

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.