

# Intravenous Immunoglobulin (IVIG)

Provider Order Form rev. 12/25/2025

## 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)*

Infuse IVIG product based on payer requirements, indication, or product availability. (Alyglo, Asceniv, Gamunex-C, Gammagard Liq., Octagam 10%, Panzyga, Privigen)

Infuse this branded IVIG product (subject to prior authorization):  
\_\_\_\_\_

Loading: \_\_\_\_\_ g/kg=\_\_\_\_\_ (dose) IV over \_\_\_\_\_ Day(s)

Maintenance: \_\_\_\_\_ g/kg=\_\_\_\_\_ (dose) IV over \_\_\_\_\_ Day(s)

Round dose to the nearest 5 grams.

## MAINTENANCE DOSE FREQUENCY *(Choose one)*

Every \_\_\_\_\_ weeks

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 per policy

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.