PURE INFUSION SUITES

IVIG Infusion Order

Fax to 801.931.2631 or
Email to intake@purehealthcare.com

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____

Patient Sex: _____ Patient Weight: _____ kg Patient Height: _____ in Patient Email: _____

Patient Status: ☐ New Patient ☐ Continuing Therapy Last Infusion Date (if applicable): _____

DIAGNOSIS DETAILS

ICD-10 Code Description: _____ ICD-10 Code: _____

Allergies: _____

ORDER DETAILS FOR IVIG BRAND

☐ **Bivigam**	_____ ☐ mg/kg ☐ gm/kg ☐ g	X ____ day(s) **OR** divided over ____ day(s)	☐ One time dose ☐ Q _____ weeks x1 year ☐ Other: _____
☐ **Gammagard 10%**	_____ ☐ mg/kg ☐ gm/kg ☐ g	X ____ day(s) **OR** divided over ____ day(s)	☐ One time dose ☐ Q _____ weeks x1 year ☐ Other: _____
☐ **Gammaked 10%**	_____ ☐ mg/kg ☐ gm/kg ☐ g	X ____ day(s) **OR** divided over ____ day(s)	☐ One time dose ☐ Q _____ weeks x1 year ☐ Other: _____
☐ **Gamunex**	_____ ☐ mg/kg. ☐ gm/kg ☐ g	X ____ day(s) **OR** divided over ____ day(s)	☐ One time dose ☐ Q _____ weeks x1 year ☐ Other: _____
☐ **Octagam 5%**	_____ ☐ mg/kg ☐ gm/kg ☐ g	X ____ day(s) **OR** divided over ____ day(s)	☐ One time dose ☐ Q _____ weeks x1 year ☐ Other: _____
☐ **Octagam 10%**	_____ ☐ mg/kg ☐ gm/kg ☐ g	X ____ day(s) **OR** divided over ____ day(s)	☐ One time dose ☐ Q _____ weeks x1 year ☐ Other: _____
☐ **Panzyga 10%**	_____ ☐ mg/kg ☐ gm/kg ☐ g	X ____ day(s) **OR** divided over ____ day(s)	☐ One time dose ☐ Q _____ weeks x1 year ☐ Other: _____
☐ **Privigen 10%**	_____ ☐ mg/kg ☐ gm/kg ☐ g	X ____ day(s) **OR** divided over ____ day(s)	☐ One time dose ☐ Q _____ weeks x1 year ☐ Other: _____

Pre-medications:

☐ Acetaminophen 650mg PO
☐ Diphenhydramine 25mg PO or IV
☐ Hydrocortisone 100mg IV
☐ Methylprednisolone 125mg IV
☐ Other Pre-medications: _____
_____

Infusion Reaction Protocol:

☐ Pure Infusion Reaction Protocol
☐ Other Reaction Protocol (Please send protocol with order)

ANCILLARY ORDERS

Lab Orders: _____ Lab Frequency: _____

Additional Orders: _____

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Patient Name: _____ DOB: _____

PROVIDER INFORMATION

Practice Name: _____ Provider Name: _____

Signature: _____ Date: _____ Time: _____

Contact Person: _____ Contact Ph: _____ Email: _____

NPI #: _____ Office Ph: _____ Office Fax: _____

PURE INFUSION SUITES PREFERRED LOCATION

City: _____ State: _____

REQUIRED DOCUMENTATION FOR EXPEDITED ORDER PROCESSING & INSURANCE APPROVAL

- ☐ Include completed order, signed by provider
- ☐ Include patient insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes (H&P) support primary diagnosis

COMMON VARIABLE IMMUNODEFICIENCY (CVID) / HYPOGAMMAGLOBULINEMIA / PARKINSON'S DISEASE (PD)

- ☐ Lab last showing Ig levels and subclasses Ig levels.
- ☐ Documentation of recurrent infections
- ☐ History of antibiotic usage - showing failure to respond to antibiotics
- ☐ Documented inadequate response to pneumococcal vaccine or tetanus/diphtheria

CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP) / GUILLAIN-BARRÉ SYNDROME (GBS)

- ☐ Labs
- ☐ Nerve conduction study, electromyography (EMG)
- ☐ Nerve and/or muscle biopsy (if available)
- ☐ Nerve conduction velocity (NCV) test results
- ☐ Tried and failed treatments
- ☐ Spinal tap (if available)

☐ Other medical necessity: _____

Pure Healthcare will provide all necessary documents to the patient's insurance company to confirm eligibility. Our patient-obsessed will inform you if further details are needed. Additionally, we'll discuss financial obligations with the patient and direct them to co-pay assistance options as required.

Please submit BOTH pages & ALL supporting documentation.
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