CURBSIDE INFUSION SERVICES

Fax To: (877) 428-1627
Email To: referrals@curbsideinfusion.com
Office: (877) 428-7248
Scheduling@curbsideinfusion.com Ext. 0
Billing@curbsideinfusion.com Ext 1

IVIG (intravenous immunoglobulin) infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Primary Immunodeficiency (PI)
- ☐ _____ Idiopathic Thrombocytopenic Purpura
- ☐ _____ Multifocal Motor Neuropathy (MMN)
- ☐ _____ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- ☐ _____ Myasthenia Gravis
- ☐ _____ Hypogammaglobulinemia
- ☐ _____ _____ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Cetirizine 10mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ _____
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____

IVIG ORDERS

BRAND

- ○ Gamunex (10%)
- ○ Gammagard (10%)
- ○ Privigen (10%)
- ○ Flebogamma DIF (10%)
- ○ Octagram (10%)
- ○ Gammaked (10%)
- ○ Gammaplex (10%)
- ○ Carimune ____ %

DOSAGE

- ○ gm per day
- ○ mg/kg over

X _____ days

FREQUENCY

- ○ one-time does/treatment
- ○ every _____ weeks

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____