



**INFUSION CENTER
OF NEW ENGLAND** — 

Checklist for Intravenous Immunoglobulin (IVIG) Referral

Patient Name: _____ DOB: _____ Date: _____

Referring Physician: _____ NPI: _____

Office Contact/Title/Email: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Best contact number for physician in case of reaction: _____

Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.

- Patient demographic information
- Insurance information and copy of insurance card/s (front and back). *Include primary and secondary insurance
- Supporting clinical notes and office visits. Two notes preferred.
 - Note should include any therapies tried/failed, and must include discussion about IVIG
 - Medication list and allergies
- Supporting lab reports/orders for IVIG treatment
 - Baseline: CBC w diff, CMP
 - *Recommended baseline:* IgA antibody, IgG trough, blood viscosity
 - *Recommended for continued therapy:* monitor renal function regularly
- IVIG Prescribing Order (see attached)

-- We will obtain prior authorization and schedule your patient as soon as possible --

Fax all information to our Infusion Coordinator: 508-698-8671

Call with any questions: 781-551-5812 ext. 112

Visit our website: www.InfusionCenterNE.com
Email: info@infusioncenterne.com

Infusion Center of New England
9 Payson Road, Suite 100, Foxboro MA 02035
Ph: 781-551-5812
Fax: 508-698-8671



Prescribing Order: Intravenous Immunoglobulin (IVIG)

Date of Order: _____

New Start Maintenance

Date of last infusion: _____

Patient Name: _____ DOB: _____ M/F: _____

Diagnosis (include ICD-10 code/s): _____

NKDA Allergies: _____

Patient Weight: _____

Premedication:

- | | |
|--|--|
| <input type="checkbox"/> Acetaminophen 1000mg PO | <input type="checkbox"/> Diphenhydramine 25mg IV |
| <input type="checkbox"/> Loratadine 10mg or Cetirizine 10mg PO | <input type="checkbox"/> Solu-medrol 125mg IV |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Other: _____ |

Lab Orders:

- | | |
|---|--|
| <input type="checkbox"/> CBC w/diff every _____ weeks | <input type="checkbox"/> CMP every _____ weeks |
| <input type="checkbox"/> Other: _____ | |

IVIG Medication Order: *IVIG product may be selected based on availability or insurance preference. Infusion rates will be determined by IVIG product manufacturer guidelines and patient tolerance.*

- Dosing: _____ gm/kg/day _____ gm/day
- Frequency: Daily x _____ days Every _____ weeks Other: _____
- Specific Brand of IVIG Required: _____

Administration:

- ✓ Do not infuse if patient showing signs or symptoms of renal dysfunction.
- ✓ Administer IVIG undiluted per medication guidelines.
- ✓ In case of infusion reaction, STOP infusion and follow NCNE infusion reaction protocol. Notify physician.

Ordering Provider Name _____ **NPI** _____

Signature _____ **Date** _____