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 option 4

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:

☐ Acetaminophen 1000mg PO
☐ Loratadine 10mg or Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Diphenhydramine 25mg IV
☐ Solu-medrol 125mg IV
☐ Other: _____

Lab Orders:

☐ CBC w/diff every _____ weeks
☐ CMP every _____ weeks
☐ 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**

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