# 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 --**

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

Call with any questions: 781-551-5812 option 4

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

**Infusion Center of New England**
18 Washington Street, Foxboro MA 02035
Ph: 781-551-5812
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# 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 ❑ _____ 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**

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