CURBSIDE INFUSION SERVICES

Fax To: 281-406-1047
Email To: referrals@curbsideinfusion.com
Office: 281-406-1046

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
- ☐ Quzyttir 10mg IVSP over 1-2 min
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ *(other)*

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 _____

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