

Edward-Elmhurst Cancer Centers

120 Spalding Drive; Suite 111; Naperville, IL 60540
Phone: 630/646-2273 Fax: 630/548-6617

24600 W. 127th Street; Plainfield, IL 60585
Phone: 630/646-2273 Fax: 630/548-6617

177 E. Brush Hill Road; Elmhurst, IL 60126
Phone: 630/646-2273 Fax: 331/221-3887

Intravenous Immune Globulin (IVIG) Order Form

Patient Name: _____ DOB: _____

Weight: _____ Height: _____ Allergies: _____

*****Please include current history and physical and any recent labs/tests, if applicable***
*PLEASE ATTACH COPY OF INSURANCE CARD WITH THIS ORDER***

Required information (anything left unanswered may result in a delay in treatment)	
Pre-Authorization # or Call Reference #	
Contact Name and Phone Number of Insurance Company	
Diagnosis and ICD 10 Code	

Pre-Medications: (Please mark all that apply)

Dosage Information (will be dispensed in appropriate volume, and administered per product instructions)			
Preferred Brand	<input type="checkbox"/> Gammagard 10% liquid <input type="checkbox"/> Other _____ Orders for anything other than Gammagard 10% liquid will require a discussion with pharmacist		
Is patient IVIG treatment naïve?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, please list all previous IVIG brands patient received: _____		
Dosing Guideline (doses will be rounded to the nearest 5 g)	Indication	Dosing	Frequency
	<input type="checkbox"/> Primary Immunoglobulin Deficiency	<input type="checkbox"/> 0.2 g/kg = _____g <input type="checkbox"/> 0.4 g/kg = _____g	_____
	<input type="checkbox"/> Chronic Lymphocytic Leukemia	<input type="checkbox"/> 0.4 g/kg = _____g	_____
	<input type="checkbox"/> Idiopathic Thrombocytopenia Purpura	<input type="checkbox"/> 0.4 g/kg = _____g <input type="checkbox"/> 1 g/kg = _____g	_____
	<input type="checkbox"/> Bone Marrow Transplant	<input type="checkbox"/> 0.5 g/kg = _____g	_____
	<input type="checkbox"/> Chronic Inflammatory Demyelinating Neuropathy	<input type="checkbox"/> 0.4 g/kg = _____g <input type="checkbox"/> 1 g/kg = _____g	_____
	<input type="checkbox"/> Guillain-Barre Syndrome	<input type="checkbox"/> 0.4 g/kg = _____g	_____
	<input type="checkbox"/> Purpura, post-transfusion	<input type="checkbox"/> ___ g/kg = _____g	_____
	<input type="checkbox"/> Myasthenia Gravis	<input type="checkbox"/> 0.4 g/kg = _____g	_____
	<input type="checkbox"/> Dermatomyositis	<input type="checkbox"/> 0.4 g/kg = _____g	_____
<input type="checkbox"/> Autoimmune Hemolytic Anemia	<input type="checkbox"/> 0.4 g/kg = _____g	_____	
<input type="checkbox"/> Other	<input type="checkbox"/> ___ g/kg = _____g	_____	
Prescription Expiration	<input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Other		

- Tylenol 650mg po prior to infusion
- Benadryl 25mg IV prior to infusion
- Benadryl 25mg po prior to infusion
- Methylprednisolone 40mg IV prior to infusion
- IV fluids _____

In the event of a hypersensitivity reaction during the infusion of this medication, the reaction protocol will be implemented. A designated provider will evaluate your patient and your office will receive notification of the event.

In the event that your patient has a central line, it will be used per the Cancer Center protocol, unless otherwise directed.

Monitoring: Monitor vital signs pre- and post-infusion or as clinically indicated.

Physician Signature: _____ **Date:** _____

Physician Name: _____

Office Phone Number: _____

Office Fax: _____

Ordering Physician NPI: _____

Edward Hospital NPI: 1427069632

Elmhurst Hospital NPI: 1548306343