

IVIG 10%



Asceniv, Gamunex-C, Privigen, Bivigam, Octagam, Panzyga, Gammagard

Provider Order Form Revised 10/29/2025

PROVIDERS: Please include the following information to expedite the order:
Patient Demographic, most recent Office Visit Note, Insurance Information, TB Results, Recent Labs

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ DOB: _____
ICD-10 code: D80. _____ D83. _____ G61.8. _____ M33.10 _____ D69.3 _____ Other: _____
ICD 10 Description: _____
 NKDA Allergies: _____ Weight (lb/kg) _____
Patient Status: New to Therapy New to Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

- Utilize Hypersensitivity protocol established by Redeemer Health Infusion and PI
- Provide nursing care and observation per Redeemer Health Infusion Policies and Procedures

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- CRP at each dose every _____
- Other: _____
- Please check this box if you do NOT authorize Redeemer Health Infusion to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

PRE-MEDICATION ORDERS

- acetaminophen (Tylenol) 500 mg/ 650 mg/ 1000 mg PO
- cetirizine (Zyrtec) 10 mg PO
- loratadine (Claritin) 10 mg PO
- diphenhydramine (Benadryl) 25 mg/ 50 mg PO/ IV
- methylprednisolone (Solu-Medrol) 40 mg/ 125 mg IV
- hydrocortisone (Solu-Cortef) 100 mg IV
- Other: _____
Dose: _____ Route: _____
Frequency: _____

SPECIAL INSTRUCTIONS

Please check this box if you DO NOT authorize Redeemer Health Infusion to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.

THERAPY ADMINISTRATION

- Immunoglobulin 10% (IVIG 10%)
 - Preferred Brand: _____
- Loading dose (if applicable):
 - _____ gm/kg or _____ gm
 - Administer x _____ day(s), or
 - divided over _____ day(s)
- Initiate maintenance dose _____ week(s) after the loading dose.
OR
- Maintenance dose: _____ gm/kg or _____ gm
Administer
 - x _____ day(s) every _____ weeks, or
 - Divided over _____ day(s) every _____ weeks
- Other (Indicate dose and frequency): _____
- **Route:** Intravenous
- **Rate:** Redeemer Infusion will establish the administration rate based on the Prescribing Information.
- Flush with 0.9% sodium chloride after infusion completion
- Refills: Zero/ for 12 months/ Other: _____
(If not indicated, order will expire one year from date signed)
- To ensure a brand name product is dispensed, the prescriber must* **handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Redeemer Infusion is authorized to administer a generic or biosimilar.**

Provider Name (Print)

Provider Signature

Date