

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

Intravenous Immune Globulin (IVIG) Unspecified Plan of Treatment

Rev. 4.29.25

PATIENT DEMOGRAPHICS:

Patient Name: _____
 Patient's Phone: _____ Address: _____
 Date of Birth: _____ City, State, Zip: _____
 Height in inches: _____ Weight: _____ LB or _____ KG Gender: _____ Allergies: _____ See list _____ NKDA _____

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

D80. _____ - Hypogammaglobulinemia	D83. _____ - Common variable immune deficiency
M33.2 _____ - Polymyositis	M33.9 _____ - Dermatopolymyositis
G61.81 - CIDP	G61.0 - Guillain Barre syndrome
G70.01 - Myasthenia Gravis with acute exacerbation	G70.00 - Myasthenia Gravis without acute exacerbation
D69.3 - ITP	_____ - Other:

REQUESTED DOCUMENTATION: PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1 Insurance information	REQUIRED WASHOUT FROM PREVIOUS THERAPY:	IF ORDER CHANGE:
2 H&P including tried and failed therapies		Continue current order until insurance approved
3 Full medication list		

[INTERNAL USE ONLY] PHARMACIST CALCULATED DOSE AND INFUSION TIME REVIEW: (IF APPLICABLE)

Pharmacist initials and date of review: _____

MEDICATION ORDERS:

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED; UNLESS OTHERWISE NOTED BELOW

IV	Diphenhydramine	25mg	50mg		PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg	Other:		Famotidine	20mg	40mg		
	Famotidine	20mg	40mg			Diphenhydramine	25mg	50mg		
	Other:					Fexofenadine	60mg	180mg		
	Prehydration with NS	250ml	500ml	1000ml		Cetirizine	10mg			
	Posthydration with NS	250ml	500ml	1000ml		Loratadine	10mg			

Pre and post infusion hydration will be given at 500ml/hour unless stated otherwise here: _____ (maximum 1L/hour)

INTRAVENOUS IMMUNE GLOBULIN DOSE/FREQUENCY:

INDUCTION: _____ gm/kg/day OR _____ gm/day **MAINTENANCE:** _____ gm/kg/day OR _____ gm/day

One time dose Daily x _____ days Once Daily x _____ days

Other: _____ Every _____ weeks Other: _____

Dosing will be rounded to the nearest 5gm for adults and nearest 1gm for pediatric patients to minimize drug waste

Specific Brand of IVIG required: _____

SPECIAL/LAB ORDERS:

IVIG product brand will be based on supply and availability of product, unless specified. Infusion rate protocol: will be based on consideration of age, medical history, risk of renal failure, and patient tolerance. Actual Body Weight will be used to dose IVIG unless otherwise specified.

****Dose will be held if patient temperature is > 101.5°F & MD will be notified**** Refills x 12 months unless noted otherwise here: _____

NURSING ORDERS: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/> Start PIV/Access CVC <input checked="" type="checkbox"/> Flush device per facility standard flushing procedure <input checked="" type="checkbox"/> Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website.
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PRESCRIBER INFORMATION:

PROVIDER NAME: _____ PHONE: _____
 ADDRESS: _____ FAX: _____
 CITY, STATE, ZIP: _____ NPI: _____

PRESCRIBER SIGNATURE: (No stamp signatures) DATE:

_____	_____	_____
Dispense as written/Brand medically necessary	Substitution permitted	



Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- Patient demographics - address, phone number, SS#, etc.**
- Insurance information - copy of the card(s) if possible**
- Plan of Treatment/Orders**
- Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.palmettoinfusion.com