Provider Order Form

IVIG (INTRAVENOUS IMMUNOGLOBULIN)

Uptiv Health

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Primary Immunodeficiency (PI) D83. _____ ☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) G61.81 ☐ Dermatomyositis M33.90

☐ Multifocal Motor Neuropathy G61.82 ☐ Polymyositis G33.20 ☐ Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg

☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg

☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg

☐ Cetrizine (Zyrtec) 10 mg PO

☐ Other: _____

THERAPY ADMINISTRATION

Uptiv Health will select the product based on payor requirements, product availability, and indication: Dose rounded to the nearest 5 gm.

Medication	Dose	Frequency
☒ IVIG, Immunoglobulin, IV	☐ Loading: _____ gm/day x _____ days; OR _____ gm/kg/course divided over _____ days	
	☐ Maintenance: _____ gm/day x _____ days; OR _____ gm/kg/course divided over _____ days every _____ weeks	

Other: _____
(Include dosage, frequency)

Refills ☐ Zero ☐ 12 months ☐ _____. Order valid for 1 year unless otherwise stated. _____

☒ Flush with 0.9% sodium chloride at infusion completion.

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ Other _____ ☐ at each dose ☐ every _____

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ TB status results

_____ _____

Provider Signature Date