Clearwater: Phone: 727.977.9717 I Fax: 727.977.9717
Tampa: Phone: 813.775.9997 I Fax: 813.775.9997
Email: intake@sageinfusion.com I Online: www.sageinfusion.com

Intravenous Immunoglobulin (IVIG) Infusion Orders

Patient Name: DOB: ☐ Male ☐ Female

Diagnosis (please provide ICD10 code)

☐ Other:

☐ NKDA Allergies:

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable):

Ordering Provider:

Provider NPI: Phone: Fax:

Practice Address: City: State: Zip Code:

PRE-MEDICATION

☐ Acetaminophen1000mg PO
☐ Diphenhydramine 25mg PO
☐ Ceterizine 10mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP

REQUIRED

☑ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (please attach)

IVIG ORDERS

DOSING:

☐ _____ gm/kg **-OR-** _____ gm **OVER** _____ day(s)

☐ _____ mg/kg **-OR-** _____ mg **OVER** _____ day(s)

Other: _____

IVIG PRODUCTS

Gamunex-C	Gammaguard
Bivigam	Privigen
Asceniv	Octagam

** Based on product availability, product recommendations may be provided.*

FREQUENCY:

Every _____ weeks for 1 year **-OR-** _____ dose(s)

OTHER:

☐ Teach and Train for **Subcutaneous Immunoglobulin (SCIG)** self administration at home with:
- ☐ Cutaquig
- ☐ Other: _____

Sage Infusion Standing Orders:

☑ Provide treatment under Sage Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

_____
Provider Name

_____ _____
Provider Signature Date

If chosen IVIG therapy is unavailable or unauthorized, Sage Infusion will reach out to the referring prescriber to discuss alternative treatment options.