Horizon Infusions

# IV Immunoglobulin Order Form

Select patient referral location: ☐ **Akron** ☐ **Blue Ash** ☐ **Cleveland** ☐ **Columbus** ☐ **Crestview Hills** ☐ **Springfield** ☐ **West Cincinnati**

☐ **Other** _____

Fax completed form to 888-977-0914. For new referrals, please **include recent labs and last two office visit notes.**

Toll Free Phone: 877-787-8720 • www.horizoninfusions.com

## 1. PATIENT INFORMATION

| | |
|---|---|
| Name: | DOB: |
| Home phone: | Other phone: |
| Email: | |
| Social Security #: | Allergies: |
| Gender: ☐ M ☐ F | Weight: ☐ Lbs ☐ Kg |
| Patient Status: ☐ New to therapy ☐ Continuing therapy | ☐ Next due date *(if applicable)*: |

## 2. PHYSICIAN INFORMATION

| | | |
|---|---|---|
| Physician's name: | | NPI#: |
| License #: | TIN#: | DEA#: |
| Address: | | |
| City: | State: | Zip: |
| Office contact: | Email: | |
| Office phone: | Office fax: | |

## 3. DIAGNOSIS INFORMATION *(and year of diagnosis)*

☐ CVID ☐ Dermatomyositis ☐ Other *(specify)*: _____

☐ PI ☐ **ICD 10** ( _____ )

## 4. INSURANCE INFORMATION

***Please submit copies of the front and back or primary and secondary insurance cards with this referral.***

## 5. PRESCRIPTION INFORMATION *(requires new order every 12 months)*

**IMMUNE GLOBULIN** _____

Administer ____GMS at ____gm/kg every _____weeks

Concentration _____%

Infusion rate: Start _____ml/hr Max _____ml/hr

Ramp up: Every _____min by _____ml/hr

Hydration *(normal saline)*: ☐ N/A

☐ Pre IG _____ml ☐ Post IG _____ml

☐ Vital signs per HI Protocol

☐ Anaphylaxis & Hydration Management per HI Protocol

**PRE-MEDICATIONS** ☐ N/A

☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg PO

☐ Fexofenadine (Allegra) 180mg PO *(or other non-sedating anti-histamine)*

☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV *(requires driver)*

☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV

☐ Prednisone _____ mg PO

☐ Other: _____

**POST-MEDICATIONS** ☐ N/A

☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg PO

☐ Prednisone _____ mg PO

☐ Other: _____

## 6. LABS

| | | |
|---|---|---|
| ☐ CBC w/Diff | ☐ each infusion | ☐ Other frequency *(specify)*: _____ |
| ☐ CRP | ☐ each infusion | ☐ Other frequency *(specify)*: _____ |
| ☐ CMP | ☐ each infusion | ☐ Other frequency *(specify)*: _____ |
| ☐ ESR | ☐ each infusion | ☐ Other frequency *(specify)*: _____ |
| ☐ Hepatic Panel | ☐ each infusion | ☐ Other frequency *(specify)*: _____ |
| ☐ IgG | ☐ each infusion | ☐ Other frequency *(specify)*: _____ |
| ☐ Renal Panel | ☐ each infusion | ☐ Other frequency *(specify)*: _____ |

☐ Quantiferon TB Gold, annually, last completed *(date)*: _____

☐ Other *(specify)*: _____

## 7. SIGNATURE *(required)*

_____ _____

PHYSICIAN'S SIGNATURE DATE