RELIANT SPECIALTY INFUSION

AIC Neurology IVIG **Fax: 833-808-0833**

Patient Information

Patient Name: _____ DOB: _____ Height: _____ Weight: _____ Patient Contact #: _____

Medical Assessment

Diagnosis (ICD-10):

- ☐ Chronic Inflammatory Demyelinating Polyneuropathy (G61.81)
- ☐ Acute Infective Polyneuritis / Guillain –Barre Syndrome (G61.0)
- ☐ Critical Illness Polyneuropathy / Acute Motor Neuropathy (G62.81)
- ☐ Dermatomytosis (M33.90)
- ☐ Lambert – Eaton Myasthenic Syndrome (G73.3)
- ☐ Multifocal Motor Neuropathy (G61.9)
- ☐ Multiple Sclerosis (G35)
- ☐ Pemphigus Foliaceus / Pemphigus Vulgaris (L10.0)
- ☐ Polymyositis (M33.20)
- ☐ Myasthenia Gravis without (acute) exacerbation (G70.00)
- ☐ Stiff Person Syndrome (G25.82)
- ☐ Myasthenia Gravis with (acute) exacerbation (G70.01)
- ☐ Other: _____

****Please include a demographics page, front and back of an insurance card-medical / RX insurance, any clinical notes with supporting diagnosis, lab-work, tests, and any other supporting documentation including past tried and / or failed therapies associated with diagnosis****

Allergies: _____

Pre-Medication Orders:

- ❑ APAP □ 325mg □ 500mg □ 650mg - PO 30 minutes before infusion.
- ❑ Diphenhydramine □ 25mg □ 50mg – PO 30 minutes before infusion.
  □ 25mg IVP □ 50mg IVP
- ❑ Alternate Oral Antihistamines: □ Cetirizine 10mg □ Loratadine 10mg □ Fexofenadine 60mg or □180mg
- ❑ Methylprednisolone □ 40mg IVP □ 125mg IVP or other ____ mg IVP
- ❑ Famotidine □ 20mg PO □ 40mg PO □ 20mg IVP □ 40mg IVP
- ❑ Ondansetron □ 4 mg IVP □ 4 mg PO

Labwork: _____ ☐ To by Drawn by Infusion Clinic ☐ Referring Provider

Medication **Patient's Current Weight: _____ lbs**

Administer IVIG

- ❑ **AIC to Determine Product**
  (or)
- ❑ **Brand: _____**
  Dosage:
  - ❑ Loading Dosage: Infuse _____ grams /kg via pump over _____ days.
  - ❑ Maintenance Dosage: Infuse _____ grams/kg via pump every _____ weeks.
  - ❑ Other Regimen: _____
  - ❑ **Refills: _____**

Hizentra

- ❑ Infuse _____ grams via Freedom 60 pump every week.
- ❑ Other Regimen: _____
- ❑ **Refills: _____**

Physician Prescription Orders Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____ Physician Name: _____

NPI #_____ Physician Signature: _____ ***Date:*** _____