AIC Rheumatology - 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)
___ Critical Illness Polyneuropathy / Acute Motor Neuropathy (G62.81)
___ Lambert – Eaton Myasthenic Syndrome (G73.3)
___ Kawasaki Disease (M30.3)
___ Polymyositis (M33.20)
___ Stiff Person Syndrome (G25.82)
___ Acute Infective Polyneuritis / Guillain –Barre Syndrome (G61.0)
___ Dermatomytosis (M33.90)
___ Multifocal Motor Neuropathy (G61.9)
___ Pemphigus Foliaceus / Pemphigus Vulgaris (L10.0)
___ Myasthenia Gravis (G70.0)
___ 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:*** ______________