

VAIL HEALTH OUTPATIENT ORDERS

322 Beard Creek Rd | Edwards, CO 81632 | Ph: 970.569.7418 | Fax: 970.470.6675

Vail Health includes services of Vail Health Hospital

IVIG Order Form

ATTACH DEMOGRAPHICS / COPY OF INSURANCE CARD, RECENT OFFICE VISIT NOTES AND IgG labs

Patient Name: _____

DOB: _____

Allergies/Adverse Reactions: _____

ICD-10: _____

Diagnosis: _____

Weight (kg): _____

☐ New Start

☐ Continuation of therapy:
(date next treatment due: _____)

Labs (to be drawn at each visit unless specified otherwise):

☐ Serum IgG

☐ CBC

☐ CMP

☐ BMP

☐ Other: _____

Pre-Meds:

☐ Acetaminophen 650 mg PO

☐ Loratadine 10 mg PO

☐ Methylprednisolone 125 mg IV

Provider Signature: _____

PRINTED PROVIDER NAME: _____

Office Name: _____

NPI: _____

State License: _____

Phone #: _____ Fax #: _____

Medication: IVIG

☐ Privigen 10% or okay to sub for insurance preferred product: _____ (Shaw staff to fill in if needed)

☐ Dispense as written: _____

Rationale: _____

Dose (check one):

☐ 0.4 gm/kg ☐ 0.5 gm/kg ☐ 0.6 gm/kg

Administration rate: Per PI or _____

Frequency (check one):

☐ Day 1 every 3 weeks

☐ Day 1 every 4 weeks

☐ Day 1 every 6 weeks

☐ Day 1 every 8 weeks

☐ Daily for 4 days

Refills (check one):

☐ 1 year

☐ Other: _____

☒ Treat hypersensitivity reaction per Vail Health Hypersensitivity Protocol

Date / Time: _____

Circle: MD / PA / NP

PHO