PREMIER INFUSION CENTER

Bivigam (Immune Globulin IV) Infusion Order Form

405-442-7577 405-442-7223
orders@premierinfusioncenter.com

Patient Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / _____
- **Phone:** _____ **Email:** _____
- **Address:** _____
- **Weight:** _____ lb/kg
- **Allergies:** ☐ NKDA ☐ _____
- **Treatment Status:** ☐ New ☐ Continued **Last Treatment Date:** ____ / ____ / ____

Diagnosis (ICD-10 Selection)

☐ D80.1 – Nonfamilial hypogammaglobulinemia
☐ D83.9 – Common variable immunodeficiency, unspecified
☐ G61.81 – Chronic inflammatory demyelinating polyneuritis
☐ G70.00 – Myasthenia gravis without exacerbation
☐ Other: _____ **ICD-10 Code:** _____

Infusion Order

- ☐ 400 mg/kg ☐ 500 mg/kg ☐ 1 g/kg ☐ Other: _____ mg/kg
- **Frequency:** ☐ Once ☐ Every 3 weeks ☐ Every 4 weeks ☐ Other: _____
- **Route:** ☐ IV ☐ SQ **Infusion Duration:** _____ hours
- **Refills:** _____

Line Use & Access

☐ Start PIV ☐ Access CVC ☐ Use PICC Line ☑ Flush per standard infusion protocol

Adverse Reaction & Anaphylaxis Orders

☑ Follow in-house protocol
☐ Other – please fax preferred reaction orders to 405-442-7223

🔹 Premedication (Optional)

- ☐ Acetaminophen: ☐ 500 mg ☐ 1000 mg ☐ PO
- ☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
- ☐ Dexamethasone: ☐ 20 mg ☐ IV
- ☐ Cetirizine: ☐ 10 mg ☐ PO
- ☐ Other: _____ **Dose:** _____ **Route:** _____

🔹 Laboratory Monitoring

☐ CBC ☐ CMP ☐ IgG Levels ☐ Renal Function (BUN/Creatinine)
☐ **Frequency:** ☐ Prior to first dose ☐ Monthly ☐ Other: _____
☐ Physician office will order labs only

🔹 Clinical Documentation Checklist

☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list

🔹 Ordering Provider & Demographics

- **Name:** _____
- **NPI:** _____ **License #:** _____
- **Contact:** _____ **Phone:** _____ **Fax:** _____
- **Email:** _____
- **Signature:** _____ **Date:** ____ / _____ / _____