



 Privigen (Immune Globulin IV 10%) Infusion Order Form

 405-442-7577  405-442-7223

 orders@premierinfusioncenter.com

 Patient Information

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

◆ **Diagnosis (ICD-10 Selection)**

- ☐ D80.0 – Hereditary hypogammaglobulinemia
- ☐ D80.1 – Nonfamilial hypogammaglobulinemia
- ☐ D83.9 – Common variable immunodeficiency
- ☐ G61.81 – Chronic inflammatory demyelinating polyneuropathy
- ☐ G70.00 – Myasthenia gravis without exacerbation
- ☐ Other: _____ **ICD-10 Code:** _____

◆ **Infusion Order**

- ☐ Dose: _____ g (rounded to nearest 5 g vial)
- ☐ Infuse over 1–4 days depending on tolerance
- ☐ Initiate rate at 0.5 mg/kg/min (0.3 mL/kg/hr); double every 30 min as tolerated
- ☐ Maximum infusion rate:
 - ☐ 8 mg/kg/min – Primary Immunodeficiency
 - ☐ 4 mg/kg/min – Immune Thrombocytopenic Purpura
 - ☐ 2 mg/kg/min – Renal dysfunction, age >65, diabetes, paraproteinemia
- ☐ Frequency: ☐ Every _____ weeks ☐ Every _____ months
- ☐ Refills: ☐ None ☐ 12 months ☐ Other: _____

◆ **Line Use & Access**

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

◆ **Adverse Reaction & Anaphylaxis Orders**

☐ Premier Infusion Center Protocol (premierinfusioncenter.com)
☐ Other – please fax preferred reaction orders to 405-442-7223

◆ **Premedication (Optional)**

☐ Acetaminophen: ☐ 650 mg ☐ PO
☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
☐ Cetirizine: ☐ 10 mg ☐ PO
☐ Methylprednisolone: ☐ 125 mg ☐ IV
☐ Other: _____ **Dose:** _____ **Route:** _____

◆ **Laboratory Monitoring**

☐ CBC ☐ CMP ☐ IgG Levels ☐ Hepatitis B Panel
☐ Other: _____
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
☐ Documentation of prior infections or antibody response testing

◆ **Ordering Provider & Demographics**

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