PREMIER INFUSION CENTER

📜 Octagam (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, unspecified
☐ G61.81 – Chronic inflammatory demyelinating polyneuritis
☐ 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 mL/kg/hr for 30 min; increase every 30 min to max 5 mL/kg/hr
☐ Maximum infusion rate:
☐ 12 mg/kg/min (ITP)
☐ 8 mg/kg/min (Primary Immunodeficiency)
☐ 3 mg/kg/min (renal dysfunction, age >65, diabetes)
☐ 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
☐ Famotidine: ☐ 20 mg ☐ IV
☐ 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:** ____ / _____ / _____