



Immune Globulin® (IVIG) Order Form

Please include the following (required):

1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)

Patient Name

DOB

Allergies

Weight

Patient Phone

Primary Diagnosis (must include ICD-10)

- Selective deficiency of IgG _____
- Common variable immune deficiency (CVID) _____
- Chronic inflammatory demyelinating polyneuropathy (CIDP) _____
- Other ICD-10 Code: _____ Diagnosis: _____

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Prescription Orders: Immune Globulin® (Intravenous)

Gamunex-C _____ grams IV every _____ weeks.

Premedications: Acetaminophen 650 mg PO Benadryl 25 mg IVP
 Zofran 4mg Solu-Medrol 40 mg IVP Other _____

Refills: 12 months or _____ infusions

Physician Name

Phone

Fax

Physician's signature

Date

**Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.
For any other questions please call (469) 480-9649.
Or visit us online at www.ntinfusioncenters.com**