



IVIG (immunoglobulin)

New Referral Continue Treatment Order Change

Patient Information:

Name: _____
Date: _____
DOB: _____
SS#: _____
Phone #: _____
Email: _____

Physician Information:

Referring Physician: _____
Address: _____

Phone #: _____
Fax #: _____

Medication Orders

Patient Weight: _____kg First Dose Maintenance Dose **MEDICATION:** Privigen Octagam

Dosing: _____ grams/kg IV _____ grams IV

Days: single day of infusion For _____ days DIVIDED dose over _____ days

Frequency: every _____ weeks One time dose every _____ months

Premeds: Benadryl 25mg IV Tylenol 1000mg PO Dexamethasone 20mg IV _____

Specific rate of mL/hr: _____

Indication / Diagnosis:

Other (please specify) _____

ICD-10 (Required) _____

MD Signature: _____ NPI#: _____ Date: _____

Required Documentation

Please send the following documents and records. This will help streamline the pre-authorization process.

- **If this is a continuation of a treatment, include the last infusion note**
- Patient demographic information sheet
- Copy of insurance card(s) front and back
- Copy of most recent office and consult notes (must include discussion of prescribed drug)
- Current medication list

Most recent diagnostics results to include:

- CMP/BMP
- CBC with differential
- Supporting labs: immunology series applicable to DX and treatment

We will contact the patient and schedule their infusion appointment once we have the insurance pre-authorization completed.

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