

Generic Immune Globulin (Human)

Please include the following to expedite the order:

Patient Demographics, Insurance Information, Labs

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ **DOB:** _____ **Gender:** ☐ M ☐ F ☐ Other _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

PRESCRIBER

Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

CLINICAL

Diagnosis Code (ICD-10): _____ **Indication:** _____

Please attach most recent applicable labs (CBC, CMP, BMP, SCr/eGFR, IgA)

Allergies: _____ **Weight:** _____ ☐ kg ☐ lbs **Height:** _____ ☐ cm ☐ in

TREATMENT

Immune Globulin (Human)

☐ 5% ☐ 10%
☐ 20% ☐ Other: _____ %

Route: ☐ Intravenous Infusion ☐ Subcutaneous Infusion

Dose

☐ _____ mg/kg
☐ _____ g/kg
☐ _____ g total

Infusion Rate

☐ Per manufacturer's recommended titration
☐ Per Restore Health IVIG/SCIG Protocol
☐ Maximum Rate: _____
☐ Other: _____

Regimen

☐ One-time dose ☐ Every _____ months
☐ Daily for _____ days ☐ Other: _____
☐ Every _____ weeks

Total dose per course: _____ g

Divide Over: _____ day(s)

Premedication Protocol:

Medication: _____ Dose: _____ ☐ IV ☐ PO
Medication: _____ Dose: _____ ☐ IV ☐ PO
Medication: _____ Dose: _____ ☐ IV ☐ PO
Sig: _____

Center will use anaphylactic and hypersensitivity protocol established by Cure Stat Infusion Services.

Quantity: _____ g/course **Refills:** _____

Special Instructions: _____

Provider Signature: _____

Date: _____