# Immunoglobulin for Primary Humoral Immunodeficiencies

## Physician Order Form

**Please fax completed referral form to (520) 202-3399**

## PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

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

**INSURANCE INFORMATION:** ***Please attach copy of insurance card (front and back).***

## DIAGNOSIS*

***ICD 10 Code Required***

- ☐ Hereditary hypogammaglobulinemia, D80.0
- ☐ Nonfamilial hypogammaglobulinemia, D80.1
- ☐ Selective deficiency of IgG subclasses, D80.3
- ☐ Antibody deficiency with near-normal Ig or with Hyperimmunoglobulinemia, D80.6

Common Variable Immunodeficiency (CVID)

- ☐ CVID with predominant abnormalities of B-cell, D83.0
- ☐ CVID with predominant immunoregulatory T-cell disorder, D83.1
- ☐ CVID with autoantibodies to B- or T-cells, D83.2
- ☐ Other CVID, D83.8
- ☐ CVID, unspecified, D83.9

☐ Other: _____, ICD 10 _____

## INFUSION ORDERS

| MEDICATION | DOSE, DIRECTIONS, and DURATION |
|---|---|
| IVIG<br>☐ Octagam 5%<br>☐ Octagam 10%<br>☐ Bivigam 10%<br>☐ Other Brand and Conc: _____ | ☐ **0.4 gm/kg** ( _____ gm* total) Infuse IV every _____ weeks x _____ months<br>☐ **0.6 gm/kg** ( _____ gm* total) Infuse IV every _____ weeks x _____ months<br>☐ ____ **gm/kg** ( _____ gm* total) Infuse IV every _____ weeks x _____ months<br>*Specify total calculated dose in grams per infusion and order to the nearest 5 grams.<br>Ramp up infusion over 90 minutes to maximum rate of 150 mL/hr (10% IVIG) or 250 mL/hr (5% IVIG), or as tolerated, then ramp down over 1 minute. |

**Is patient currently receiving therapy above from another facility?** ☐ **NO** ☐ **YES**

If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

## OTHER ORDERS

**LAB ORDERS:** Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____ ☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

**PRE-MEDICATION ORDERS:**

- ☐ No premeds ordered at this time
- ☐ Acetaminophen 650mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV
- ☐ Other: _____

## REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

## REQUIRED CLINICAL DOCUMENTATION

**Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.**

☐ **See Attached Medical Records**

**Lab Results (required)**

☐ Immunoglobulin (IgG total, IgG subclasses, IgA, and IgM), serum levels ☐ Other: _____

☐ Vaccine Challenge (pre-/post-vaccination serotype titers)

☐ Yes ☐ No Does the patient have documented history of recurrent bacterial sinopulmonary infections?

- ☐ Required multiple courses or prolonged antibiotic therapy
- ☐ Failure of prophylactic antibiotic therapy
- ☐ Hospitalizations for URI in the past 12 months
- ☐ Other: _____

☐ Yes ☐ No Does the patient have documented low pretreatment IgG level?

☐ Yes ☐ No Does the patient demonstrate inadequate antibody response to polysaccharide and/or protein antigen(s)?

If Yes, please attach pre- and post-vaccination titer labs performed prior to initiation of Ig.

If No, specify reason why antibody challenge was not completed: _____

- ☐ Pneumovax, Date of Vaccination: _____
- ☐ Prevnar, Date of Vaccination: _____
- ☐ Tetanus/Diphtheria, Date of Vaccination: _____
- ☐ Hemophilus, Date of Vaccination: _____

*For continuation of therapy requests:*

☐ Yes ☐ No Has the patient shown clinical improvement on therapy (e.g., reduction in frequency and/or severity of infections, decreased hospitalization, reduction in number of missed school or workdays, improved quality of life, etc.)?