Trinity Health Muskegon & Shelby Infusion Clinics
Muskegon: 1500 Sherman BLVD, Muskegon, MI 49444
Shelby: 72 S. State St. Shelby, MI 49455
Fax: 231-727-4328

Immune Globulin IV

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. Trinity Health Muskegon will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ____/____/____ **Site of Service:** ☐ TH Muskegon ☐ TH Shelby

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

Patient Name: _____
Date of Birth: ____/____/____
Weight: _____kg **Height:** _____cm
Allergies: _____

Primary Insurance: _____
Member ID: _____
Secondary Insurance: _____
Member ID: _____

Diagnosis

Diagnosis Code (ICD-10): _____
Indication: _____
Target start date: _____

Lab Orders

No labs required. Labs to be ordered by physician.
☐ Other: _____

Pre-medications:

☐ No pre-medications are routinely given. Pre-medications may be ordered at physician discretion.

☐ Acetaminophen	650mg	Oral
☐ Loratadine	10mg	Oral
☐ Diphenhydramine	50mg	☐ Oral ☐ IV
☐ Famotidine	20mg	☐ Oral ☐ IV
☐ Hydrocortisone	100mg	IV
☐ Methylprednisolone	125mg	IV
☐ Other:		

℞

Immune Globulin (Human) Intravenous (IGIV)

☐ Pharmacist to select

☐ **Privigen** - ***preferred*** ☐ **Gammagard** ☐ **Octagam** ☐ **Gamunex-C** ☐ **Gammagard S-D**

Dose:
☐ _____gram/kg* **OR** ☐_____grams

Frequency:
☐ Once ☐ Daily ☐ Every ___week(s) ☐ Other:_____

Special Orders (i.e., repeat every 12 weeks):

☐ _____

* Dose will be calculated based on IBW or adjusted body weight as applicable, and rounded per Together Care dose-rounding logic

Nursing Orders:

Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy if necessary: sodium chloride 0.9 % bolus 500 mL PRN; acetaminophen tablet 650 mg PRN; albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg PRN; albuterol HFA inhaler 2 puff PRN; epinephrine injection 0.3 mg PRN; famotidine injection 20 mg PRN; diphenhydramine injection 50 mg PRN; diphenhydramine injection 25 mg PRN; hydrocortisone sodium succinate injection 100 mg PRN

Provider Name: _____
Office Phone Number: _____
Attending Physician Name: _____
(If ordering provider is an advanced practice practitioner, attending physician required)

Provider Signature: _____
Office Fax Number: _____

Note: This order is valid for 12 months from date of physician signature.