



Immune Globulin IV

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

Order Date: _____

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: _____
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Diagnosis Diagnosis Code (ICD-10): _____ Indication: _____ Target start date: _____	Lab Orders No labs required. Labs to be ordered by physician. <input type="checkbox"/> Other: _____
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Pre-medications:

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

<input type="checkbox"/> Acetaminophen	650mg	Oral
<input type="checkbox"/> Loratadine	10mg	Oral
<input type="checkbox"/> Diphenhydramine	50mg	<input type="checkbox"/> Oral <input type="checkbox"/> IV
<input type="checkbox"/> Famotidine	20mg	<input type="checkbox"/> Oral <input type="checkbox"/> IV
<input type="checkbox"/> Hydrocortisone	100mg	IV
<input type="checkbox"/> Methylprednisolone	125mg	IV
<input type="checkbox"/> Other: _____		

Rx Immune Globulin (Gamunex Liquid 10%) Intravenous (IGIV)

Dose:

_____ gram/kg* OR _____ grams

Frequency:

Once Daily Every ____ week(s) Other _____

Duration:

_____ doses 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: _____	Provider Signature: _____
Office Phone Number: _____	Office Fax Number: _____
Attending Physician Name: _____	

*(If ordering provider is an advanced practice practitioner, attending physician required)
 Note: This order is valid for 12 months from date of physician signature.*