

Intravenous Immunoglobulin (IVIG)

Provider Order Form rev. 8/23/26



PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____ Mobile Phone Number: _____
Weight (lbs/kg): ☐ NKDA Allergies: _____
Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

REQUIRED SUPPORTING DOCUMENTATION (Please include the following with the order to support processing & insurance approval)

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

DIAGNOSIS ICD-10 CODE (Provider must specify)

☐ D80.0 Hereditary hypogammaglobulinemia ☐ D80.1 Nonfamilial hypogammaglobulinemia ☐ D80.3 Selective deficiency of immunoglobulin
☐ G61.81 Chronic inflammatory demyelinating polyneuropathy ☐ D83.9 Common variable immunodeficiency, unspecified
☐ G70.00 Myasthenia Gravis without (acute) exacerbation ☐ G70.01 Myasthenia gravis with (acute) exacerbation
☐ Other: _____

PRIMARY MEDICATION ORDER

Arbor Infusion will select the product based on payor requirements, product availability, and indication: Asceniv, Gammagard Liquid, Gamunex-C, Octagam, Panzyga, Privigen

• Administration rate: Arbor Infusion will establish the administration rate based on therapy prescribing information

• Refill for 12 months unless otherwise noted: _____

☐ Loading Dose (as applicable): _____
Give maintenance dose _____ days after loading dose
☐ mg/kg ☐ gm/kg x ☐ _____ days ☐ divided over _____ day(s) ☐ one time dose ☐ other: _____
☐ grams

☐ Maintenance Dose: _____
☐ mg/kg ☐ gm/kg x ☐ _____ days ☐ divided over _____ day(s) ☐ every _____ weeks x 1 year ☐ other: _____
☐ grams

☐ Other (indicate dose and frequency): _____

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: pre-meds not typically indicated

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ famotidine (Pepcid) 20 mg IV
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ Other: _____
Dose: _____ Route: _____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ Other: _____

NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

Ordering Provider (Print) _____ Provider Signature _____ Provider NPI _____ Date _____

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zipcode: _____

ARBOR INFUSION FAX NUMBERS (Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)

☐ Arbor Infusion Fishers (317) 981-1772