

Patient Name: _____ DOB: _____ Sex: M F
 Address: _____ Patient SSN: _____
 City: _____ State: _____ Zip: _____ Phone: _____

Demographics Attached

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

Primary Diagnosis: _____ ICD-10 Code: _____
 Patient Weight: _____ lbs. Height: _____ Diabetic Yes No
 Allergies: _____

Does patient already have a line? No Yes - type of line: _____

Has patient previously received IVIG? No Yes - Brand: _____

Date of last infusion: _____

Labs Attached

If No, can first dose be given at home? Yes No

MEDICATION ORDERS

IVIG (IV Immunoglobulin Order: _____ do not substitute

IVIG Dose: _____ grams/kg = _____ grams (round to nearest vial size) infuse intravenously

Repeat dose daily x _____ consecutive days total, repeat dose: monthly x _____ months
 Other: _____

Repeat dose weekly x _____ weeks total

Repeat does monthly x _____ months total

Others: _____

Rate of infusion: 30-150 ml/hr as tolerated by patient (increase rate gradually every 30 minutes by 20-30 ml/hr

Other: _____

Pre-medication: *To be administered 15-30 minutes before infusion*

Diphenhydramine: 500mg IV 25mg IV Acetaminophen: 1000mg PO 500mg PO

Other: _____

Flush Orders: Normal saline 1-50mL pre or post infusion prn D5W 1-50mL pre or post infusion prn

Heparin 100 units per mL 1-5mL post infusion prn Heparin 10 units per mL 1-5mL post infusion prn

Adverse Reaction Medications: Diphenhydramine 25-50 mg PO or IV prn allergic reaction

Epinephrine 1:1000 subcut IM prn severe allergic reaction

Other: _____

Nursing Services requested: Yes No

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____

NPI: _____ DEA: _____ License: _____

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

Phone: _____ Fax: _____ Contact Person: _____

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