Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

IVIG Order Form

Patient Name: _____ DOB:_____
Phone:_____ Address: _____
City: _____ State:_____ Zip:_____ Email: _____
Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:

☐ Other_____ ICD-10:_____

ORDER FOR IVIG:

Allow Nevada Infusion to determine the IVIG Product:

***Infuse IVIG product as required by patient's insurance determination. (Preferred IVIG product to be determined after benefits investigation by intake team)**

Dose: _____ ☐ mg/kg ☐ gm/kg ☐ g Frequency: X ____ day(s) OR divided over ____ day(s)
☐ One time dose ☐ Q _____ weeks x1 year ☐ Other: _____

Provider Requests Specific IVIG Brand:

☐ Bivigam 10% ☐ Gammagard 10% ☐ Gamunex 10% ☐ Octagam 5%
☐ Octagam 10% ☐ Panzyga 10% ☐ Privigen 10%

Dose: _____ ☐ mg/kg ☐ gm/kg ☐ g X _____day(s) OR divided over_____ day(s)
☐ One time dose ☐ Q _____ weeks x1 year ☐ Other: _____

PRE-MEDICATIONS:

☑ Acetaminophen 650mg PO
☑ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
☑ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
☐ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion
LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

Revised: 05/2025

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Patient Name: _____ DOB:_____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

☐ Signed provider orders (page 1)

☐ Patient demographic and insurance information

☐ Patient's current medication list

☐ Supporting recent clinical notes and H&P (to support primary diagnosis)

☐ Supporting documentation to include past tried and/or failed therapies

Common Variable Immunodeficiency (CVID)/ Hypogammaglobulinemia/Parkinson's Disease (PD):

- ☐ Lab last showing Ig levels and subclasses Ig levels
- ☐ Documentation of recurrent infections
- ☐ History of antibiotic usage - showing failure to respond to antibiotics
- ☐ Documented inadequate response to pneumococcal vaccine or tetanus/diphtheria

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)/Guillain-Barre Syndrome (BGS):

- ☐ Labs
- ☐ Nerve conduction study, electromyography (EMG)
- ☐ Nerve and/or muscle biopsy (if available)
- ☐ Nerve conduction velocity (NCV) test results
- ☐ Tried and failed treatments
- ☐ Spinal tap (if available)

☐ Other medical necessity documentation (please include): _____

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