



IVIG Order Form

Select patient referral location: Anchorage Palmer Fairbanks

Please fax or securely email to 1-907-921-7669 or RX@luxinfusion.com.
For new referrals, please **include recent labs and last two office visit notes.**
Clinic Phone Number: 1-907-744-1944 · luxinfusion.com

1. PATIENT INFORMATION	
Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: M F	Weight:
Patient Status: New to therapy Continuing therapy	Next due date (if applicable):

2. PHYSICIAN INFORMATION	
Physician's Name:	NPI#:
License #: TIN#:	DEA#:
Address:	
City:	State: Zip:
Office contact:	Email:
Office phone:	Office fax:

3. DIAGNOSIS INFORMATION (and year of diagnosis)	
CVID Dermatomyositis Other (specify):	
PI ICD 10 ()	

4. INSURANCE INFORMATION	
Please submit copies of the front and back or primary and secondary insurance cards with this referral.	

5. PRESCRIPTION INFORMATION (requires new order every 12 months)	
IMMUNE GLOBULIN _____	PRE-MEDICATIONS N/A
Administer ___ GMS at ___ gm/kg every ___ weeks	Acetaminophen 500mg 650mg 1000mg PO
Concentration ___%	Cetirizine (Zyrtec) 10mg PO (or other non-sedating anti-histamine)
Infusion rate: Start ___ ml/hr Max ___ ml/hr	Diphenhydramine (Benadryl) 25mg 50mg
Ramp up: Every ___ min by ___ ml/hr	PO IV (requires driver)
Hydration (normal saline): N/A	Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV
Pre IG ___ ml Post IG ___ ml	Prednisone _____ mg PO
	Other: _____
Per Protocol LUX Infusion Rate	POST-MEDICATIONS N/A
Vital signs per LUX Protocol	Acetaminophen 500mg 650mg 1000mg PO
Anaphylaxis & Hydration Management per LUX Protocol	Prednisone _____ mg PO
May round dosage to nearest 2.5 Grams	Other: _____

6. SIGNATURE (required)	
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PHYSICIAN'S SIGNATURE DATE