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 ______________________________

Administer ____GMS at ____gm/kg every ____ weeks

Concentration _____%

Infusion rate: Start ____ml/hr Max____ml/hr

Ramp up: Every_____min by ____ml/hr

Hydration *(normal saline)*: N/A

Pre IG ____ml Post IG____ml

Vital signs per LUX Protocol

Anaphylaxis & Hydration Management per LUX Protocol

May round dosage to nearest 2.5 Grams

PRE-MEDICATIONS N/A

Acetaminophen 500mg 650mg 1000mg PO

Cetirizine (Zyrtec) 10mg PO *(or other non-sedating anti-histamine)*

Diphenhydramine (Benadryl) 25mg 50mg PO IV *(requires driver)*

Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV

Prednisone ___________ mg PO

Other: ______________________________

POST-MEDICATIONS N/A

Acetaminophen 500mg 650mg 1000mg PO

Prednisone ___________ mg PO

Other: ______________________________

6. SIGNATURE *(required)*

PHYSICIAN'S SIGNATURE DATE

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