Edward-Elmhurst Cancer Centers
120 Spalding Drive; Suite 111; Naperville, IL 60540
Phone: 630/646-2273 Fax: 630/548-6617

24600 W. 127th Street; Plainfield, IL 60585
Phone: 630/646-2273 Fax: 630/548-6617

177 E. Brush Hill Road; Elmhurst, IL 60126
Phone: 630/646-2273 Fax: 331/221-3887

Intravenous Immune Globulin (IVIG) Order Form

Patient Name: _____ DOB: _____

Weight: _____ Height:_____ Allergies:_____

*****Please include current history and physical and any recent labs/tests, if applicable*****
PLEASE ATTACH COPY OF INSURANCE CARD WITH THIS ORDER

Required information (anything left unanswered may result in a delay in treatment)	
Pre-Authorization # or Call Reference #	
Contact Name and Phone Number of Insurance Company	
Diagnosis and ICD 10 Code	

Pre-Medications: (Please mark all that apply)

Dosage Information (will be dispensed in appropriate volume, and administered per product instructions)			
Preferred Brand	□ Gammagard 10% liquid □ Other _____ **Orders for anything other than Gammagard 10% liquid will require a discussion with pharmacist**		
Is patient IVIG treatment naïve?	**☐ Yes ☐ No** **If no, please list all previous IVIG brands patient received:** _____		
Dosing Guideline (doses will be rounded to the nearest 5 g)	**Indication**	**Dosing**	**Frequency**
	□ Primary Immunoglobulin Deficiency	□ 0.2 g/kg = _____g □ 0.4 g/kg = _____g	_____
	□ Chronic Lymphocytic Leukemia	□ 0.4 g/kg = _____g	_____
	□ Idiopathic Thrombocytopenia Purpura	□ 0.4 g/kg = _____g □ 1 g/kg = _____g	_____
	□ Bone Marrow Transplant	□ 0.5 g/kg = _____g	_____
	□ Chronic Inflammatory Demyelinating Neuropathy	□ 0.4 g/kg = _____g □ 1 g/kg = _____g	_____
	□ Guillain-Barre Syndrome	□ 0.4 g/kg = _____g	
	□ Purpura, post-transfusion	□ __ g/kg = _____g	_____
	□ Myasthenia Gravis	□ 0.4 g/kg = _____g	_____
	□ Dermatomyositis	□ 0.4 g/kg = _____g	_____
	□Autoimmune Hemolytic Anemia	□ 0.4 g/kg = _____g	_____
	□Other	□ __ g/kg = _____g	_____
Prescription Expiration	**☐ 3 months ☐ 6 months ☐ 12 months ☐ Other**		

- ☐ Tylenol 650mg po prior to infusion
- ☐ Benadryl 25mg IV prior to infusion
- ☐ Benadryl 25mg po prior to infusion
- ☐ Methylprednisolone 40mg IV prior to infusion
- ☐ IV fluids _____

In the event of a hypersensitivity reaction during the infusion of this medication, the reaction protocol will be implemented. A designated provider will evaluate your patient and your office will receive notification of the event.

In the event that your patient has a central line, it will be used per the Cancer Center protocol, unless otherwise directed.

Monitoring: Monitor vital signs pre- and post-infusion or as clinically indicated.

Physician Signature: _____ **Date:** _____
Physician Name: _____ **Ordering Physician NPI:** _____
Office Phone Number: _____ **Swedish Hospital NPI: 1831151257**

Office Fax: _____
Revision/Review Date: 12/2024