Immune Globulin

Provider Order Form

Newport Superior Infusion
1501 Superior Ave, Suite 202
Newport Beach, CA 92663
Phone: 949-601-6001
Fax: 866-542-8631

PATIENT INFORMATION

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight lbs / kg: Height in / cm:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☐ Provide nursing care and follow anaphylaxis reaction treatment per Newport Infusion Protocol
- Nurse to place peripheral IV prior to IVIG infusion

☐ Patient has IV access Type :_____

☐ Patient has NOT previously used immune globulin

☐ Patient has previously used immune globulin:

Brand:_____ Dose: _____

Frequency:_____ Route :_____

Date of Last Infusion: _____

PRE-MEDICATION ORDERS

To be administered 30 minutes prior to infusion

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ methylprednisolone (Solu-Medrol) 125mg IV

☐ IV hydration prior to IVIG infusion:☐ 250mL / ☐ 500mL

☐ Other:_____

Dose: _____

Route:_____

Frequency: _____

THERAPY ADMINISTRATION

☐ IVIG ☐ SCIG
(Immune globulin based on Newport Infusion availability)

☐ **Do not substitute:**
- Preferred IG:_____
- Reason:_____
_____

Directions
- Dose (grams): _____
- Frequency: _____
- Duration:_____

Rate: Choose one

☐ Infuse 30mL/hr for 30 min, 60mL/hr for 30 min, 90mL/hr for 30 min, 150mL/hr thereafter as tolerated

☐ Other infusion rate:
_____

Refills: ☐ Zero / ☐ for 12 months / ☐ _____

(if not indicated order will expire one year from date signed)

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ Other: _____

SPECIAL INSTRUCTIONS

Provider Name (Print) **Date**

Provider Signature