NORTH TEXAS INFUSION CENTERS

Immune Globulin® (IVIG) Order Form

Please include the following (required):
1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)

_____ _____
Patient Name **DOB**

_____ _____ _____
Allergies **Weight** **Patient Phone**

Primary Diagnosis (must include ICD-10)

☐ Selective deficiency of IgG _____
☐ Common variable immune deficiency (CVID) _____
☐ Chronic inflammatory demyelinating polyneuropathy (CIDP) _____
☐ Other ICD-10 Code: _____ Diagnosis: _____

Prescription Orders: Immune Globulin® (Intravenous)

Gamunex-C _____ grams IV every _____ weeks.

Premedication: ☐ Acetaminophen 650 mg PO ☐ Benadryl 25 mg IVP
☐ Zofran 4mg ☐ Solu-Medrol 40 mg IVP ☐ Other_____

Refills: ☐ 12 months or ☐ for _____infusions

_____
Provider Name **Phone** **Fax**

_____
Provider's signature **Date**

Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.
For any other questions please call (469) 480-9649.
Or visit us online at www.ntinfusioncenters.com