



MEDICATION ORDERS

INTRAVENOUS IMMUNOGLOBULIN

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:
Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy – Last Treatment Date:	Next Due Date:

REFERRAL STATUS		
<input type="checkbox"/> New Referral	<input type="checkbox"/> Dose or Frequency Change	<input type="checkbox"/> Order Renewal

INFUSION OFFICE PREFERENCE (Optional)	
Preferred Location:	<input type="checkbox"/> Montgomery <input type="checkbox"/> Prattville

DIAGNOSIS AND ICD 10 CODE	
Diagnosis:	ICD-10 Code:

REQUIRED DOCUMENTATION/TESTING	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis

PRE-MEDICATION ORDERS
<input checked="" type="checkbox"/> Diphenhydramine(Benadryl) 25mg PO prior to infusion
<input checked="" type="checkbox"/> Hydrocortisone(Solu-Cortef) 50mg IV prior to infusion
<input type="checkbox"/> Acetaminophen(Tylenol) 1000mgPO prior to infusion
<input type="checkbox"/> Other:

MEDICATION ORDERS
<input type="checkbox"/> IVIG _____ gm/day IV x _____ days
<input type="checkbox"/> IVIG _____ gm/day IV divided over _____ days
<input type="checkbox"/> IVIG _____
(* include dosage, frequency and other special instructions)
Refills: <input type="checkbox"/> None <input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> Other:
<ul style="list-style-type: none">New orders and progress notes required at least once yearly. A medication substitution may be required based on insurance payer policy due to preferred versus non-preferred medications or based on payer step therapy guidelines.Please note: if an infusion reaction occurs, the Montgomery Cancer Center provider will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.

PROVIDER INFORMATION			
Office Contact Name:			
Prescribing Providers Name:		Provider NPI:	
Office Address:	City:	State:	Zip:
Office Phone Number:		Office Fax Number:	
Physician Signature:		Date:	

Contact us with questions at: Montgomery (334) 273-7000 or Prattville (334) 351-1000
Fax completed form and all documentation to Montgomery (334) 260-2011 or Prattville (334) 358-1207