LAWRENCE COUNTY
Memorial Hospital
DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICDE 10 CODE

Diagnosis:
☐ ICD 10 Code:
☐ _____ ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ The signed order form by the provider ☐ Patient demographics AND insurance information ☐ Prior authorization with reference number	☐ Clinical/Progress notes (must be within 1 year) ☐ Labs and tests supporting primary diagnosis Pt may be required to submit a pregnancy test prior to treatment

List of tried and failed therapies, including duration of treatment:
1) _____

MEDICATION ORDERS

Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____

Medication	**Gammagard Liquid 10% (Immune Globulin Infusion, Human)** J-code: J1569 — billed per 500 mg unit (1 gram = 2 units) | Route: IV

Dosing — Select indication and complete dose/frequency

☐ **PI** Primary Humoral Immunodeficiency	Dose: 300–800 mg/kg IV Prescribed dose: _____ mg/kg = _____ grams Frequency: ☐ Every 3 weeks ☐ Every 4 weeks ☐ Other: _____ Adjust dose based on monitored IgG trough levels and clinical response.
☐ **MMN** Multifocal Motor Neuropathy	Prescribed dose: _____ g/kg = _____ grams Frequency: ☐ Every 3 weeks ☐ Every 4 weeks ☐ Other: _____ Individualize duration beyond 6 months based on patient response and need.
☐ **CIDP** Chronic Inflammatory Demyelinating Polyneuropathy	Prescribed dose: _____ g/kg = _____ grams Frequency: ☐ Every 3 weeks ☐ Every 4 weeks ☐ Other: _____ Individualize duration beyond 6 months based on patient response and need.
☐ **Other**	Indication: _____ Dose: _____ grams Frequency: _____

Infusion Rate: Start 0.5 mL/kg/hr × 30 min; increase every 30 min as tolerated to max 5 mL/kg/hr. Reduce rate for patients ≥65 yrs or at risk for renal/thrombotic events (max 2 mL/kg/hr).

PREMEDICATIONS/ LAB ORDERS

☐ Acetaminophen _____ mg PO PRN	☐ CBC ☐ prior to each infusion or ☐ Frequency: _____
☐ Benadryl _____mg ☐ PO or ☐ IV	☐ CMP ☐ prior to each infusion or ☐ Frequency: _____
☐ Other: _____	☐ Other: _____ Date:_____

ADDITIONAL ORDERS/INFORMATION		
PRESCRIBER INFORMATION		
Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS – GAMMAGARD LIQUID (IVIG)