IVIG Order Form

Pre-filled order form for IVIG (intravenous immunoglobulin) — Pooled antibody therapy for immune and neurologic conditions

REFERRING PROVIDER

PROVIDER NAME | NPI | DEA (IF CONTROLLED) | SPECIALTY

PRACTICE / CLINIC NAME | OFFICE PHONE | OFFICE FAX

OFFICE CONTACT NAME | CONTACT PHONE | CONTACT EMAIL

PATIENT INFORMATION

PATIENT LAST NAME | FIRST NAME | MIDDLE INITIAL

DATE OF BIRTH | SEX | PATIENT PHONE | BEST TIME TO CONTACT

ADDRESS | CITY, STATE, ZIP

INSURANCE

PRIMARY INSURANCE | MEMBER ID | GROUP #

SECONDARY INSURANCE (IF ANY) | MEMBER ID | GROUP #

DIAGNOSIS & CLINICAL JUSTIFICATION

PRIMARY DIAGNOSIS | ICD-10 CODE

SECONDARY DIAGNOSIS (IF APPLICABLE) | ICD-10 CODE

Common indications for this medication: *Primary immunodeficiency (CVID and others), Chronic inflammatory demyelinating polyneuropathy (CIDP), Multifocal motor neuropathy, Myasthenia gravis, Guillain-Barré syndrome, Immune thrombocytopenia (ITP), Kawasaki disease*

BRIEF CLINICAL SUMMARY / JUSTIFICATION FOR THERAPY

PRIOR THERAPIES TRIED AND OUTCOME

IVIG REFERENCE

Generic name:	intravenous immunoglobulin
Specialty:	Immunology & Neurology
Typical infusion time:	3–6 hours
Typical schedule:	Typically every 3–4 weeks
Biosimilars / brands:	Gammagard, Privigen, Octagam, Gamunex-C, Bivigam, HyQvia

MEDICATION ORDER

MEDICATION (DEFAULT: IVIG)

GENERIC / ALT (INTRAVENOUS IMMUNOGLOBULIN)

STRENGTH / FORMULATION

DOSE

FREQUENCY (TYPICAL: TYPICALLY EVERY 3&NDASH;4 WEEKS)

DURATION (TYPICAL: 3&NDASH;6 HOURS)

ROUTE

PRE-MEDICATIONS (IF ANY)

SPECIAL INSTRUCTIONS

ANTICIPATED START DATE

 # OF DOSES AUTHORIZED

SUBSTITUTION ALLOWED (Y/N)

BIOSIMILAR ACCEPTABLE (Y/N)

REQUIRED LABS & MONITORING

Check all labs the prescriber requires Ascribe to verify before each infusion:

- ☐ CBC w/ differential
- ☐ CMP
- ☐ Liver function panel
- ☐ Hepatitis B/C panel
- ☐ TB screen (T-SPOT or QFT)
- ☐ Pregnancy test (urine)
- ☐ Iron studies (ferritin, TSAT)
- ☐ Vitamin levels (B12, D, folate)
- ☐ Other (specify below)

OTHER LABS / MONITORING REQUIREMENTS

PRESCRIBER SIGNATURE

By signing below I certify that this order is medically necessary, that I am the prescribing provider for this patient, and that I have reviewed the patient's clinical history relevant to this therapy. Ascribe Infusion Therapy is authorized to coordinate scheduling, prior authorization, and benefits verification on the patient's behalf.

PRESCRIBER SIGNATURE	PRINTED NAME	DATE

Form code: ARB-ORDER-IVIG · Submit to Ascribe Infusion Therapy by fax to [FAX NUMBER] or via secure portal. Ascribe Infusion will confirm receipt within one business day and begin prior authorization the same day. Questions: [PHONE] · hello@ascribeinfusion.com