RELIANT SPECIALTY INFUSION

AIC Dermatology - IVIG **Fax: 833-808-0833**

Patient Information

Patient Name: _____ DOB: _____ Height: _____ Patient Contact #: _____

Medical Assessment

Diagnosis (ICD-10):

- □ Dermatomytosis (M33.90)
- □ Kawasaki Disease (M30.3)
- □ Cicatricial Pemphigoid (L12.1)
- □ Pyoderma Gangrenosum (L88)
- □ Pemphigus Foliaceus / Pemphigus Vulgaris (L10.0)
- □ Bullous Pemphigoid (L12.0)
- □ Chronic Urticarial (L50.9)
- □ Other: _____

****Please include a demographics page, front and back of an insurance card-medical / RX insurance, any clinical notes with supporting diagnosis, lab-work, tests, and any other supporting documentation including past tried and / or failed therapies associated with diagnosis****

Allergies: _____

Pre-Medication Orders:

- ❑ APAP □ 325mg □ 500mg □ 650mg - PO 30 minutes before infusion.
- ❑ Diphenhydramine □ 25mg □ 50mg – PO 30 minutes before infusion OR □ 25mg IVP □ 50mg IVP
- ❑ Alternate Oral Antihistamines: □ Cetirizine 10mg □ Loratadine 10mg □ Fexofenadine 60mg or □180mg
- ❑ Methylprednisolone □ 40mg IVP □ 125mg IVP OR other _____ mg IVP
- ❑ Famotidine □ 20mg PO □ 40mg PO □ 20mg IVP □ 40mg IVP
- ❑ Ondansetron □ 4 mg IVP □ 4 mg PO

Labwork: _____ To by Drawn by: □ Infusion Clinic □ Referring Provider

Medication

Patient's Current Weight: _____ lbs / kg (circle one)

Administer IVIG

- ❑ **AIC to Determine Product (based on payor directives / availability) OR**
- ❑ **Specific Brand: _____**

Dosage:

- ❑ Loading Dose: _____ grams /kg via over _____ days
- ❑ Maintenance Dose: _____grams/kg every _____ weeks
- ❑ Other Regimen: _____
- ❑ **Maintenance Refills:_____**

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- ❑ _____ grams every week
- ❑ Other Regimen: _____
- ❑ **Maintenance Refills:_____**

Physician Prescription Orders

Address: _____ Phone: _____Fax: _____

Clinic Contact: _____Physician Name: _____

NPI #_____Physician Signature: _____***Date:*** _____