RELIANT SPECIALTY INFUSION

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

Patient Information

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

Medical Assessment

Diagnosis (ICD-10):

- ❑ Chronic Inflammatory Demyelinating Polyneuropathy (G61.81)
- ❑ Critical Illness Polyneuropathy/Acute Motor Neuropathy (G62.81)
- ❑ Lambert – Eaton Myasthenic Syndrome (G73.3)
- ❑ Kawasaki Disease (M30.3)
- ❑ Polymyositis (M33.20)
- ❑ Stiff Person Syndrome (G25.82)
- ❑ Acute Infective Polyneuritis / Guillain –Barre Syndrome (G61.0)
- ❑ Dermatopolymyositis, unspecified (M33.90)
- ❑ Multifocal Motor Neuropathy (G61.9)
- ❑ Pemphigus Foliaceus / Pemphigus Vulgaris (L10.0)
- ❑ Myasthenia Gravis (G70.0)
- ❑ 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)

IVIG

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

  Dosage:
  - ❑ Loading Dose: _____ grams /kg over _____ days
  - ❑ Maintenance Dose:_____ grams/kg every _____ weeks
  - ❑ Other: _____
  - ❑ **Maintenance Refills**: ___

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- ❑ _____ grams every _____ day / week (circle one)
- ❑ Other: _____
- ❑ **Maintenance Refills:____**

Physician Prescription Orders

Address: _____ Phone: _____Fax: _____

Clinic Contact: _____Physician Name: _____

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