Site of Care
☐ Home Infusion
☐ Infusion Center
☐ Doctor's Office

Fax Referral to (855) 644-3687 or Email: Referrals@sandshealth.com

IVIG ORDER FORM

Sands Health will select the product based on product availability, indication and insurance requirement

Gammagard Liquid 10% Gammagard S/D Bivigam 10%* Gamunex-C 10%
Octagam 5% Octagam 10% Privigen 10% Panzyga 10%

☐ DO NOT SUBSTITUTE. Administer brand:_____ *Bivigam: Available through Infusion center only

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Mobile Number: _____

Patient Weight: _____ Patient Height: _____ Allergies: _____

Other Medications: _____

DIAGNOSIS (Provider must specify)

☐ Chronic Inflammatory Demyelinating Polyneuropathy, ICD10: _____
☐ Primary Immunodeficiency, ICD10: _____
☐ Myasthenia Gravis, ICD10: _____
☐ Other: _____

Prior to treatment – ensure the following information is complete and attached with referral:

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Bendaryl 25 mg PO ☐ Methylprednisolone (Solu-Medrol) _____ mg IVP

☐ Other: _____ Dose: _____ Route: _____

☐ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
IVIG	☐ _____ Grams/Kg ☐ _____ Grams *Dose will be rounded up to nearest vial size.	IV ☐ Administer as single day infusion ☐ Divide dose over _____ days	☐ Once ☐ Every _____ weeks ☐ Every_____ months

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

LABS/SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

PROVIDER INFORMATION

Provider Name: _____ Provider NPI: _____ Contact:_____

Phone: _____ Fax: _____ Email Address:_____

Signature: _____ Date: _____