

IVIG ENROLLMENT FORM

Ph: 714.698.4325 | Fax: 714.485.7063 | altheainfusion.com | altheapharmacy.com



* Patient Name: _____ DOB: / / Height: _____ *Weight: _____ kg Date: / /

Allergies: _____ Email: _____ Ship to: Patient
 Address: _____ Ph: _____ * Prescriber Signature MD Office
 Althea Location:

* Prescriber: _____ Ph: _____ Fax: _____

DOCUMENTS TO INCLUDE WITH REFERRAL DIAGNOSIS

- * • Patient demographics
- * • Copies of insurance card (front and back)
- * • Pharmacy Card
- * • **Recent Lab Results:** CBC with differential, Quantitative immunoglobulins (IgG, IgA, IgM), Antibody titers (e.g., pneumococcal, tetanus), Hepatitis B & C panel, TB screening (Quantiferon or TST), HIV screening
- * • Specialist consults and recent progress notes
 - Prior medications and therapies (failed or inadequate response)
 - Relevant imaging studies (MRI, CT, X-ray, etc.)
 - Baseline functional assessment with detailed symptom history

- D83.0 – Common Variable Immunodeficiency (CVID) D80.3 – Selective Deficiency of IgG
- D75.82 – Immune Thrombocytopenia (ITP)
- G61.81 – CIDP
- G70.01 – Myasthenia Gravis
- G35 – Multiple Sclerosis (RRMS)
- G61.0 – Guillain-Barré Syndrome
- G61.82 – Multifocal Motor Neuropathy (MMN) G25.82 – Stiff-Person Syndrome
- L10.0 – Pemphigus Vulgaris
- D69.3 – Immune Thrombocytopenic Purpura (ITP)
- Other: _____

IVIG PRESCRIPTION DOSAGE AND ADMINISTRATION

Alyglo® (immune globulin IV)	Alyglo 5 g / 50 mL Alyglo 10 g / 100 mL Alyglo 20 g / 200 mL	Dose: _____ g/kg Frequency: _____
Asceniv™ (immune globulin IV)	Asceniv 1 g/vial	Dose: _____ g/kg Frequency: _____
Bivigam® (immune globulin IV)	Bivigam 1 g/vial	Dose: _____ g/kg Frequency: _____
Gammagard® (immune globulin IV/SC)	Gammagard 1 g / 10 mL	Dose: _____ g/kg Frequency: _____
Gamunex®-C (immune globulin IV/SC)	Gamunex-C 10% Gamunex-C 10% 1 g / 10 mL vial	Dose: _____ g/kg Frequency: _____
Gammaked™ (immune globulin IV/SC)	Gammaked 10% 5 g / 50 mL	Dose: _____ g/kg Frequency: _____
Octagam® (immune globulin IV)	Octagam 5% 1 g / 20 mL Octagam 10% 2 g / 20 mL	Dose: _____ g/kg Frequency: _____
Panzyga® (immune globulin IV)	Panzyga 10% 2.5 g / 25 mL vial	Dose: _____ g/kg Frequency: _____
Privigen® (immune globulin IV)	Privigen 10% 5 g vial	Dose: _____ g/kg Frequency: _____

SCIG PRESCRIPTION DOSAGE AND ADMINISTRATION

Cutaquig® (immune globulin SC)	Cutaquig 16.5% 1 g / 6 mL (OCT) Cutaquig 1 g / 6 mL vial (Pfz)	Dose: _____ g/kg Frequency: _____
Hizentra® (immune globulin SC)	Hizentra 20% 1 g syringe / 5 mL	Dose: _____ g/kg Frequency: _____
HyQvia® (immune globulin SC)	HyQvia SubQ Kit 2.5 g / 25 mL	Dose: _____ g/kg Frequency: _____
Xembify® (immune globulin SC)	Xembify 20% 1 g vial / 5 mL	Dose: _____ g/kg Frequency: _____
Nabi-HB® (hepatitis B immune globulin)	Nabi-HB 5% / 5 mL SDV	Dose: _____ g/kg Frequency: _____

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol - Flushing per S.A.S.H. protocol (Saline, Administer medication, Saline, Heparin) specific volumes and concentrations based on patient's line type.

Premedications & Other Medications - Infusion supplies as per protocol. Anaphylaxis Kit orders as per protocol.

Acetaminophen _____ mg PO prior to infusion Diphenhydramine _____ mg PO
 Methylprednisolone Other: _____