Novella Infusion

Patient Name:
DOB:
Date of Last Infusion
Insurance:

Clinic Location:
Merrimack, NH ☐
Concord, NH ☐

IVIG Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ (ICD-10) Primary Humoral Immunodeficiency

_____ (ICD-10) Idiopathic Thrombocytopenia Purpura

_____ (ICD-10) Chronic Inflammatory Demyelinating Polyneuropathy

_____ (ICD-10) Other: _____

- Monitor vital signs every 30 minutes and with each rate change.
- Administration guidelines vary by IVIG product and brand. Review manufacturer instructions for infusion rate, titration schedule and filtration requirements.
- If infusion-related reaction occurs, stop infusion, and follow Hypersensitivity Reaction Management Policy/Protocol as clinically indicated.

Pre-medications:

☐ Tylenol 500 mg orally ☐ Benadryl 25 mg orally

☐ Other: _____

Administer IVIG _____mg/kg x current weight (_____ kg) = _____

☐ Brand name medically necessary; dispense only _____

Dose may be rounded by up to 10% to nearest vial size per protocol. Provider check here (☐) to PROHIBIT dose rounding.

☐ Administer as a single infusion ☐ Divide dose over _____ days

Frequency:

☐ Every _____ weeks ☐ Every _____ months

☐ Once ☐ Other: _____

Additional orders (ex. hydration):

Provider name (print): _____ Date:_____

Provider signature: _____ Time: _____