



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

Medical Assessment (Diagnosis ICD-10 Code)

- | | |
|--|--|
| ☐ Chronic Inflammatory Demyelinating Polyneuropathy (G61.81) | ☐ Acute Infective Polyneuritis / Guillain –Barre Syndrome (G61.0) |
| ☐ Critical Illness Polyneuropathy / Acute Motor Neuropathy (G62.81) | ☐ Dermatomyositis (M33.90) |
| ☐ Lambert – Eaton Myasthenic Syndrome (G73.3) | ☐ Multifocal Motor Neuropathy (G61.9) |
| ☐ Pemphigus Foliaceus / Pemphigus Vulgaris (L10.0) | ☐ Polymyositis (M33.20) |
| ☐ Myasthenia Gravis without (acute) exacerbation (G70.00) | ☐ Stiff Person Syndrome (G25.82) |
| ☐ Myasthenia Gravis with (acute) exacerbation (G70.01) | |
| ☐ Multiple Sclerosis (<i>Please choose one of the following</i>) | ☐ G35A Relapsing-remitting MS |
| ☐ Other: _____ | ☐ G35B _____ (0,1, or 2) Primary progressive MS |
| | ☐ G35C _____ (0, 1 or 2) Secondary progressive MS |
| | ☐ G35D MS, unspecified |
| | ☐ G710.36 Limb-girdle muscular dystrophy due to fukutin-related dysfunction |

****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 OR kg

IVIG

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

Dosage:

- ☐ Loading Dose: _____ grams /kg over _____ days
- ☐ Maintenance Dose: _____ grams/kg via pump every _____ weeks
- ☐ Other Regimen: _____
- ☐ Maintenance Refills: _____
- ☐

Hizentra

- ☐ _____ grams every week
- ☐ Other Regimen: _____
- ☐ Maintenance Refills: _____

Physician Prescription Orders Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____ Physician Name: _____

NPI # _____ Physician Signature: _____ Date: _____