Atrium Health

Atrium Health Infusion Center

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Infusion Center Concord **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Pineville **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Southpark **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Huntersville **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Kenilworth, a facility of CMC **Fax:** 704-512-5390
	☐ Atrium Health Infusion Center Abbey Place, a facility of CMC **Fax:** 704-512-5390
	☐ Atrium Health Infusion Center Cabarrus, a facility of CMC **Fax:** 704-512-5390

IVIG Infusion Order (Revised 11/11/2025)

All orders with a √ will be placed.

Patient Demographics:

Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:

Allergies: (please list all allergies or attach list)

☐ NKDA

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)

☐ D80._____ - Hypogammaglobulinemia	☐ G70.01 - Myastenia Gravis with acute exacerbation
☐ M33.2_____ - Polymyositis	☐ D69.3 - ITP
☐ G61.81 - CIDP	☐ D83._____ - Common variable immune deficiency
☐ M33.9_____ - Dermatopolymyositis	☐ G61.0 - Guillain Barre Syndrome
☐ G70.00 - Myastenia Gravis without acute exacerbation	☐ Other:

Required Documentation: (*required prior to scheduling*)

Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:
Complete Medication List - Include all tried and failed meds	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ No

Provider Communication:

☑ Atrium Health preferred product will be utilized unless otherwise indicated by payer:
- Atrium Health Preferred Product: Gamunex-C
- For patients with IgA deficiency with antibodies: Gammagard S/D (low IgA)
- For patients with intolerance to Gamunex-C: Gammagard S/D (low IgA)

Nursing Communication:

☑ Start PIV/Access CVC and flush device per approved Atrium Health protocol.
☑ Obtain vital signs PRE- and POST-treatment. Obtain vital signs every hour during treatment.
☑ Monitor patient for signs of reaction for 30mins after completion of first 2 infusions and subsequent infusions PRN if previous signs of reaction observed.

Pre-Medications: (Administer all pre-medications 30mins prior to treatment)

☐ Acetaminophen (Tylenol) 650mg PO ONCE
☐ Diphenhydramine (Benadryl) 25mg PO ONCE
☐ Diphenhydramine (Benadryl) 25mg IV ONCE
☐ Loratadine (Claritin) 10mg PO ONCE
☐ Ketorolac (Toradol) 30mg IV ONCE
☐ Methylprednisolone sodium succinate (Solu-Medrol) 125mg IV ONCE

Hydration:

☐ Sodium chloride 0.9% 500mL bolus IV ONCE

Infusion Therapy:

☐ Immune Globulin (human) (Gamunex-C) IV

☐ Dose:	If Gamunex-C is not selected, please indicate the reason:
☐ Frequency:	

☐ Immune Globulin G 10% IgQ 0-50 (Gammagard S/D Less IgA) IV

☐ Dose:	Is the patient IgA deficient:
☐ Frequency:	☐ Yes ☐ No

☑ **Atrium Health will authorize the Atrium preferred IVIG product unless otherwise indicated by payer.**
- If the patient has a contraindication to the 2 products above, please call **704-468-3400** (AH Infusion Centers Southpark, Concord, and Pineville) or **704-512-5370** (AH Infusion Centers Kenilworth, Cabarrus, Abbey Place, facilities of CMC) to request an order for Privigen or Gammagard liquid.
- If the payer prefers a product other than the 2 above, the preferred product order will be faxed to the referring provider office for completion.

Supportive Care Medications:

☑ Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first if not given as a pre-medication.
☑ Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.
☑ Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting.

Hypersensitivity Protocol:

☑ Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.

Prescriber Information:

Provider Name:	Phone: Fax:
Practice Name:	NPI:
Address:	Office Contact:
City, State, Zip:	Office Contact Phone Number:

Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted

Signature:	Date: