UNIVERSITY OF MICHIGAN HEALTH-WEST
MICHIGAN MEDICINE
Infusion Center

Sending a Referral to University of Michigan Health-West

Please follow the steps below to send a referral:

1. Review the **Required Documentation Checklist** below and include listed documents
2. Fill out all fillable fields on the digital form **OR** print and fill form out manually.
3. Fax completed order form with all required documentation to **(616) 475-3118**

Required Documentation Checklist

If we do not receive all documents below with your referral or do receive an incomplete medication order form, the order is subject to delays. **It may take up to 14 business days for the patient's insurance* company *to approve or deny our authorization request.*

- ☐ Complete Medication Order Form
- ☐ Patient Demographics
- ☐ Current Medication List and H&P
- ☐ Recent Visit Notes
- ☐ Lab Results
- ☐ Patient's Insurance Card
- ☐ Existing Prior Authorizations (*if applicable*)

Intravenous Immune Globulin (IVIG)

For adult patients (> 16 years)
Order Form

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PATIENT INFORMATION Referral Status: ○ New Referral ○ Updated Order ○ Order Renewal

Date: Patient Name: DOB:

Allergies: Weight (kg): Height (cm):

ICD-10 Code(s) & Description (required):

☑ (required) Demographics, insurance, lab results, meds and recent visit notes are attached.

Does the patient have an existing prior authorization: ○ Yes (please include) ○ No (UMHW to obtain)

PRESCRIBING OFFICE

Contact Name: Contact Phone Number

Ordering Provider: Provider NPI:

Practice Name: Phone: Fax:

Practice Address:

CLINICAL HISTORY

Is this referral **URGENT** (to be administered within 5-7 days)? ○ Yes ○ No

If yes, please list rationale: _____

Does patient have chronic kidney disease? ○ Yes ○ No

If yes, what stage and ICD10 code? _____

Is patient on any form of dialysis? ○ Yes ○ No

THERAPY ADMINISTRATION

Treatment Conditions: **HOLD FOR THE FOLLOWING PARAMETERS**: _____

_____ ○ None

Start date: _____

Nursing Orders:

- Contact onsite provider if infusion reaction occurs
- If the patient reacts, stop infusion and institute rescue protocol. Replace infusion with normal saline IV and notify on-site provider. Staff will notify prescriber if reaction occurs.
- Vital signs:
  - Baseline
  - 15 minutes into infusion
  - Before each rate increase until maximum rate is achieved
  - 30 minutes after the maximum rate is achieved
  - Every hour until the infusion is complete
  - 30 minutes post infusion
- Patient may be discharged 30 minutes after completion of infusion if stable

Pre-medications: (Given unless crossed out by prescriber):

- Acetaminophen (Tylenol) 650 mg PO prior to IVIG
- Diphenhydramine (Benadryl) 25 mg IV prior to IVIG
- Famotidine 20 mg IV prior to IVIG
- 0.9% Sodium Chloride 100 ml/hour

☐ Other: _____

Intravenous Immune Globulin (IVIG) Product Selection:

☑ **Octagam 10%** -formulary/preferred product. (Non-sucrose-based product)

☐ Other: _____

If an alternative product (Flebogamm, Privigen 10%, Gammagard 10%, Gamunex-C 10% etc) is needed, please note reason above.

Dose/Frequency:

See "Guidelines for IVIG dosing and administration." Doses should be capped at 100 grams per day. Total dose over 5 days should not exceed 2 g/kg. IVIG dose is based on ideal body weight (IBW) unless 1) patient weighs more than 130% of their IBW; adjusted body weight (AdjBW) is used or 2) actual body weight is less than IBW; then actual body weight is used.

☑ IVIG _____ grams/kg
(usual dose range 0.4-2 g/kg)

☐ One time only

☐ Daily for _____ days

☐ Every _____ weeks for ☐ one year ☐ _____ doses

*Administer IVIG per UMHW Intravenous Immune Globulin (IVIG) Medication Usage Guide

Supportive Medications:

- Meperidine 12.5 mg once as needed for infusion reaction (rigors)
- Emergency orders per infusion hypersensitivity policy

Additional Notes from Referring Office:

Provider Name (Print)	**Provider Signature**	**Date**

UM Health-West Infusion Center
Cascade Campus | 4055 Cascade Rd SE | Grand Rapids, MI 49546
p **616.252.5202** | f **616.475.3118** | UofMHealthWest.org