



St. Charles Health System

Adult Ambulatory Infusion Order
Intravenous Immune Globulin (IVIG)

Patient Name:
Date of Birth:

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Treatment Start Date: _____ **Allergies:** _____
Weight: _____ **kg** **Height:** _____ **cm**

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety

- 1. FACE SHEET with complete INSURANCE information and patient CONTACT information**
- 2. Recent VISIT NOTE to support treatment (if not available in Epic)**
- 3. LAB RESULTS for any required prescreening (if not available in Epic)**
- 4. DIAGNOSIS CODE** _____
- 5. Patient NAME and DATE OF BIRTH on EVERY page faxed**

GUIDELINES FOR ORDERING

- 1. Send FACE SHEET and H&P or most recent chart note.**
2. For doses over 1 g/kg/day and depending on patient tolerability, may administer course in divided doses over 2 to 5 consecutive days.
3. Pharmacist to round dose to nearest whole vials. Pharmacist to order appropriate combination of vial sizes to administer total ordered dose. For doses that require more than one vial, orders should be prescribed as "once" order(s). For multiple consecutive days: Round dose to administer same dose each day and set interval to "every visit" (for example, for dose of 70 grams over 2 days, order as 35 grams with "every visit" interval).
4. IVIG will be infused per manufacturer guidelines, unless the rate is otherwise specified. Infuse per guideline provided with medication and titrate based on patient tolerability. Begin infusion at 0.3 mL/kg/hr, double rate every 15 min up to 1.2 mL/kg/hr, then increase by 1.2 mL/kg/hr every 30 min up to the recommended max (usually 2.4 or 4.8 mL/kg/hr).
5. If the preferred brand of IVIG (Privigen) is unavailable, or on short supply the pharmacist will interchange the product with another brand. Please specify if a patient cannot tolerate a specific brand.
6. Adjusted Body Weight will be used when a patient has an Actual Body Weight (ABW) greater than 120% of Ideal Body Weight (IBW). Otherwise, IBW or ABW will be used, whichever is lowest.
 - a. $IBW \text{ Males (kg)} = 50 + (2.3 \times (\text{height in inches} - 60))$
 - b. $IBW \text{ Females (kg)} = 45.5 + (2.3 \times (\text{height in inches} - 60))$
 - c. If height < 60 inches, use 50 kg (male) and 45.5 kg (female) to calculate IBW
 - d. $Adjusted \text{ Body Weight} = IBW + 0.4 (\text{Actual Body Weight} - IBW)$

LABS: (must check to order)

- CBC with Auto Differential, Routine, ONCE, every (visit)(days)(weeks)(months) – **Circle One**
- Complete Metabolic Set, Routine, ONCE, every (visit)(days)(weeks)(months) – **Circle One**
- IGG (serum), Routine, ONCE, every (visit)(days)(weeks)(months) – **Circle One**



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NURSING ORDERS:

1. Vital signs, every visit: Assess vital signs before initiating IVIG infusion. During the infusion assess vital signs at 15 minutes, with each rate increase, then hourly after reaching maximum rate.
2. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion, recommended for all patients)

Note to provider: Please select which medication below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

- Acetaminophen (TYLENOL) tablet oral, 650 mg, ONCE, every visit
- Diphenhydramine (BENADRYL) tablet/capsule oral, 25 mg, ONCE, every visit
- Cetirizine (ZYRTEC) tablet oral, 10 mg, ONCE, every visit (**Choose as alternative to diphenhydramine if needed**)

MEDICATIONS:

Applies to all orders below, products listed in preference to St. Charles

- Privigen 10% (St. Charles preferred brand)
- Gamunex-C 10%
- Gammagard 10%
- Octagam 10%

(Pharmacist will round dose to nearest 5 gm vial and modify brand/selection based upon availability during order verification)

- 0.2 g/kg IV, ONCE, every visit
- 0.4 g g/kg IV, ONCE, every visit
- 0.5 g/kg IV, ONCE, every visit
- 1 g/kg IV, ONCE, every visit
- _____ g IV, ONCE (for doses titrated to IgG level), every visit

Interval:

- Once
- Daily x _____ doses
- Every _____ weeks for _____ doses
- Other _____



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Non-Standard Specifications:

Patient requires a specific brand of IVIG (other than listed above) Please specify here:

Patient requires IVIG at a 5% concentration (note: currently not a standard stocked item)

Custom administration approach required, specify rate below:

INFUSION MONITORING/REACTION:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebuler, AS NEEDED x1 dose for hypersensitivity reaction

Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

Patient will be treated at the following infusion location:

- St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION



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Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

Plan will expire 1 year after signature date at which time a new order will need to be placed