IV Immune Globulin (IVIG) Order Form

DEMOGRAPHICS

PatientName: _____ DateofBirth: _____ Gender: □F□M

Home Phone: _____ Cell: _____ Work: _____

Address: _____

City: _____ State: _____ Zip: _____

LegallyResponsibleRepresentative: _____ RelationshiptoPatient: _____

Diagnosis: □Primary Immune Deficiency □Idiopathic ThrombocytopeniaPurpura(ITP) □HIV

IDC-10: _____ □MultipleSclerosis(MS) □Chronic LymphocyticLeukemia(CLL) □AllogenicBMT

□ Kawasaki'sDisease □Chronic Inflammatory Demyelinating Polyneuropathy(CIDP)

□ MyastheniaGravis □Other: _____

Has the patient previously received IVIG? □No □Yes –Whatbrand? _____

Previous reaction to IVIG? □No □Yes -Pleaseexplain: _____

Past Medical History (RPh may recommend additionalpremedication):

□ Migraine □Thrombosis □Diabetes □Renaldysfunction

Medication Orders:

- □ Alteplase2mgIVtodeclotcentralIVaccessperInfusionSolutionsprotocolasneededforocclusion.
- □ FlushlinewithD5W,0.9%NaCland/orHeparin10units/mlor100units/mlperInfusionSolutionsprotocol.
- □ Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1ratio).

Dose/Frequency: RPh will round to nearestpackagesize **Dose based on IBW for obesepatients

_____g/kg (0.4-2 g/kg)IV every _____ □day(s) □week(s) for _____ □doses □week(s) □months,

then _____g/kg (0.4-2 g/kg)IV every _____ □day(s) □week(s) for _____ □doses □week(s) □months

- □ Specific brand (if patient is intolerant to particularbrand): _____
- □ Do not infuse other medications through the same line asIVIG.
- □ Following manufacturer's recommendations, initiate infusion at low end of range (usually around 30 ml/hr) x 15 minutes. Increase slowly every 15 minutes if tolerated until entire dose isinfused.
- □ **Slow infusion**, notify physician, and administer reaction management medications if indicated for onset of flushing, fever,nausea,diaphoresis,hypotension,urticaria,chills,dizziness,headache,bodyaches,vomiting,myalgia,chest tightness, tachycardia, or shortness ofbreath.
- □ **Stop infusion**, administer reaction management medications, activate EMS, and notify physician for onset of life threateninghypersensitivityreactionsincludinganaphylaxis,acuterenalinsufficiency,thromboticevents,oraseptic meningitis.

Premedication (15 to 30 minutes before infusion):

Diphenhydramine: □50mgIV □25mgIV

Acetaminophen: □1000mgPO □500mgPO

□ Other: _____

To Manage InfusionReactions:

- □ Methylprednisolone 125mg IV x1 dose PRN severe urticaria, pruritis, orSOB
- □ Infusion Reaction Management per Infusion Solutions Protocol:
  - □ Acetaminophen 500mg (1,000mg if severe) PO Q4h PRN aches or temperature increases≥2□F
  - □ Diphenhydramine 50mg IV x1 dose PRN urticaria, pruritis, orSOB
  - □ Epinephrine 1:10,000: 0.1mg IV slowly over 5 min PRN anaphylaxis. May repeat Q 5 to 15 min x3.
- □ Other: _____

Nursing Orders:

- □ If no central IV access, RN to insert peripheral IV, rotate site every 72 to 120 hours or asneeded.
- □ Obtain weight before eachdose.
- □ Monitorvitalsigns(temp,HR,RR,BP)beforetherapy, every15minx1hour,everyhour,andatcompletionofinfusion.
- □ Ifaninfusionreactionoccurs,decreaserateby30ml/hrevery15minutesandmonitorvitalsignsuntilsymptoms subside. If reaction persists or worsens, stop infusion and notifyphysician.
- □ Other: _____

Labs: □Serum Creatinine (recommend at least every6months) every _____

□ every _____

PrescriberSignature *Date*

Please Print Name *NPI*