



134 Prince Avenue, Suite B  
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 Phone (360) 933-4892  
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Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Wt: \_\_\_\_\_ Ht: \_\_\_\_\_

Allergies: \_\_\_\_\_

### IV Immune Globulin (IVIG) Order Form

◆ **Orders are initiated unless crossed out by provider.**

**Check box to initiate order.**

Please complete this form and fax to (360)933-1197

<b>Diagnosis:</b>	<input type="checkbox"/> Primary Immune Deficiency	<input type="checkbox"/> Idiopathic Thrombocytopenia Purpura (ITP)	<input type="checkbox"/> HIV
<b>IDC-10:</b> _____	<input type="checkbox"/> Multiple Sclerosis (MS)	<input type="checkbox"/> Chronic Lymphocytic Leukemia (CLL)	<input type="checkbox"/> Allogenic BMT
	<input type="checkbox"/> Kawasaki's Disease	<input type="checkbox"/> Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	
	<input type="checkbox"/> Myasthenia Gravis	<input type="checkbox"/> Other: _____	
Has the patient previously received IVIG?	<input type="checkbox"/> No <input type="checkbox"/> Yes - _____		
Past Medical History (RPh may recommend additional premedication):			
<input type="checkbox"/> Migraine	<input type="checkbox"/> Thrombosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Renal dysfunction

**Medication Orders:**

- ◆ Alteplase 2mg IV to de clot central IV access per Infusion Solutions protocol as needed for occlusion.
- ◆ Flush line with D5W, 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol.
- ◆ Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).

Dose/Frequency: RPh will round to nearest package size      \*\*Dose based on IBW for obese patients  
 \_\_\_\_\_ 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 particular brand): \_\_\_\_\_
- ◆ Do not infuse other medications through the same line as IVIG.
- ◆ 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 is infused.
- ◆ **Slow infusion**, notify physician, and administer reaction management medications if indicated for onset of flushing, fever, nausea, diaphoresis, hypotension, urticaria, chills, dizziness, headache, body aches, vomiting, myalgia, chest tightness, tachycardia, or shortness of breath.
- ◆ **Stop infusion**, administer reaction management medications, activate EMS, and notify physician for onset of life threatening hypersensitivity reactions including anaphylaxis, acute renal insufficiency, thrombotic events, or aseptic meningitis.

**Premedication (15 to 30 minutes before infusion):**

Diphenhydramine:       50mg IV       25mg IV  
 Acetaminophen:       1000mg PO       500mg PO  
 Other: \_\_\_\_\_

**To Manage Infusion Reactions:**

- Methylprednisolone 125mg IV x1 dose PRN severe urticaria, pruritis, or SOB
- ◆ Infusion Reaction Management per Infusion Solutions Protocol (adult doses listed below; adjusted for pediatrics):
  - Acetaminophen 500mg (1,000mg if severe) PO Q4h PRN aches or temperature increases  $\geq 2^{\circ}\text{F}$
  - Diphenhydramine 50mg IV, PO, or IM x1 dose PRN urticaria, pruritis, or SOB
  - Epinephrine 1:10,000: 0.1mg IV slowly over 5 min PRN anaphylaxis. May repeat Q 5 to 15 min x 3.  
 -OR- Epinephrine 1:1,000: 0.5 mg IM PRN anaphylaxis. May repeat Q 5 to 15 min x 3.
  - Oxygen at 8 L/min by mask or 4 L/min by nasal cannula PRN chest pain or SOB
- Other: \_\_\_\_\_

**Nursing Orders:**

- ◆ If no central IV access, RN to insert peripheral IV, rotate site every 72 to 120 hours or as needed.
- ◆ Obtain weight before each dose.
- ◆ Monitor vital signs (temp, HR, RR, BP) before therapy, every 15 min x1 hour, every hour, and at completion of infusion.
- ◆ If an infusion reaction occurs, decrease rate by 30 ml/hr every 15 minutes and monitor vital signs until symptoms subside. If reaction persists or worsens, stop infusion and notify physician.
- Other: \_\_\_\_\_

**Labs:**     Serum Creatinine (recommend at least every 6 months)      every \_\_\_\_\_  
 \_\_\_\_\_      every \_\_\_\_\_

\_\_\_\_\_  
*Prescriber Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Please Print Name*