477 W. Horton Rd.
Bellingham, WA 98226
Phone (360) 933-4892
Fax (360) 933-1197

Patient Name: ______________________________

Date of Birth: ________________ Wt: _______Ht:_______

IV Access: ______________________________

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

Diagnosis: ______________________________ ICD-10: ______________

Prescreening:

Has the patient previously received IVIG? ❑ No ❑ Yes, brand and date: ______________________________

Past Medical History (RPh may recommend additional premedication):

❑ Migraine ❑ Thrombosis ❑ Diabetes ❑ Renal dysfunction

Medication Orders:

- IVIG (Brand will be selected by pharmacy, unless specified) ❑Specific brand (if medically necessary): __________
  - Dose: _________g/kg (final dose determined by Pharmacy) **OR** ____________grams (total dose)
  - Frequency: Give IV every ______________________________
  - Other instructions: ______________________________

PHARMACY USE

Pharmacist will use actual body weight (ABW) or adjusted body weight (adjBW) if ABW is >30% more than the ideal body weight (IBW), unless prescriber indicates otherwise.

ABW = ________kg IBW = _________kg If applicable, adjBW (IBW+0.4[ABW-IBW]) =________kg

Final dosing weight: __________

Calculated IVIG dose: (round to nearest 5g or available vial size) _________ RPh initial/date: ____________

- Following manufacturer's recommendations, initiate infusion at low end of range. Increase slowly every 15 to 30 minutes if tolerated until entire dose is infused.
- Alteplase 2mg IV to declot 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).

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
- ❑ 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