Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy

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

Patient Name: _____

Date of Birth: _____ Weight: _____

IV Access:_____ Height:_____

Allergies: _____

IV Immune Globulin (IVIG) Order Form

Please fax this form, copies of insurance cards, demographics, and supporting clinical documentation to **(360) 933-1197** to facilitate an efficient referral. Thank you for choosing Infusion Solutions!

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 ONLY

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 as needed, and remove at end of therapy.
- 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

KEY: ◆ Orders are initiated unless crossed out by provider. **❑ Check to initiate order.**