IVIG INFUSION ORDERS

Patient Name:_____ Date of Birth:_____

Diagnosis:_____

NOTE: Screen patients at each visit for active infection before any treatment is given, including TB. If active infection present, notify physician immediately.

NOTE: Screen patient for signs/symptoms of kidney problems (e.g., urinary retention, hematuria, change in amount of urine passed, or weight gain). Use IVIG cautiously in patients with renal impairment and ensure adequate hydration before administration.

NOTE: Monitor for signs/symptoms of thrombosis. Ensure adequate hydration before administration.

NOTE: IVIG may diminish the therapeutic effect of some live vaccinations. Call pharmacy for exceptions to this rule.

The following orders will be enacted unless a specific order is written to the contrary

1. Weigh patient prior to infusion
2. **EFFECTIVE 11/01/2017, Pharmacy will dispense Gammagard®** for all IVIG orders unless otherwise ordered by provider. *Specify IVIG brand if Gammagard is contraindicated:*_____
3. Pharmacy will round all IVIG doses (up or down) to the nearest 5 gram unit.
4. Pharmacy will calculate dose in obese patients (i.e., greater than 20% of Ideal body wt) based on *Adjusted* body weight
5. **Loading Dose (if applicable): IVIG** _____ grams **−− *OR* −−** _____ mg/kg/DOSE
6. **Loading Frequency:**_____**,** over ____ hrs or per WDH protocol.
7. **Maintenance Dose: IVIG _____** grams **−− OR −− _____** mg/kg/DOSE, over ___ hrs or per WDH protocol.

Doses / Frequency of Maintenance dose (specify):

____	❑ **daily**	❑ **consecutive**
____	❑ **weekly**	❑ **non−consecutive**
____	❑ **every other week**	❑ **Additional info / Other (specify):**_____
____	❑ **monthly**	
____	❑ **2x per week**	
____	❑ **3x per week**	
____	❑ **every ___ weeks**	

8. **IV fluids:** ***NOTE: IVIG must be infused through a dedicated line****. Compatibility with other drugs or IV solutions has only been established for 5% Dextrose (D5W).*

❑ 0.9% Sodium Chloride _____ml at ___ ml/hour *(must administer through a separate IV line)*

❑ Other (specify): _____ *(if other than D5W, must administer through a separate IV line)*

9. If pre−medication is required, check to activate order(s) below:

❑ Acetaminophen (Tylenol) 650mg PO X 1	❑ Patient instructed to take at home
❑ Loratadine (Claritin) 10mg PO X 1 **−−OR−−** ❑ Diphenhydramine (Benadryl) 50mg PO X 1	❑ Patient instructed to take at home
❑ Prednisone ___ po PM night before infusion	❑ Patient instructed to take at home
❑ Prednisone ___ po AM morning of infusion	❑ Patient instructed to take at home
❑ Methylprednisolone (Solu−Medrol) _____ mg IV push over 2−3 minutes	

10. **Additional medications *(specify):***_____

_____

_____

_____

−−−−− See Page 2 for Infusion Reaction Protocol −−−−−

Patient Name:_____ Date of Birth:_____

Infusion reaction protocol:

11. ***The following orders will be enacted unless a specific order is written to the contrary:***

For ***MINOR*** infusion reaction (fever, flushing, chills):

- Stop infusion for 10 minutes
- Restart infusion at last tolerated level, then increase rate per protocol

For ***MODERATE*** infusion reaction (pruritis, uticaria, arthralgia, rash, nausea/vomiting):

- STOP infusion
- Give diphenhydramine 25mg IV x 1. May repeat X 1 in 10 minutes if reaction does not subside.
- Restart infusion at last tolerated level only if patient is asymptomatic and vital signs are stable. After 15 minutes may increase rate per protocol.
- Notify physician

For ***SEVERE*** infusion reaction or anaphylaxis (hypotension, hypertension, chest pain, dyspnea, wheezing, palpitations):

- **STOP administration of IVIG immediately**
- For ANAPHYLAXIS: Epinephrine (EpiPen) 0.3 mg (0.3 ml) IM x 1 STAT, administered into anterolateral aspect of the thigh
- For HYPOTENSION: Bolus IV 0.9% Sodium Chloride 1000 ml over 1 hour
- Diphenhydramine (Benadryl) 25mg IV X 1 dose
- Methylprednisolone (Solu−Medrol) 125mg IV x 1 dose
- Notify physician
- Transport the patient to the emergency department

_____ _____

Physician Signature **Date / Time**