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-- Patient instructed to take at home
   - Diphenhydramine (Benadryl) 50mg PO X 1
   - 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 ----
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, urticaria, 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