Intravenous Immune Globulin (IVIG)

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: ____________kg **Height:** ____________cm

Allergies: ____

Diagnosis Code: ____

Treatment Start Date: _____________ **Patient to follow up with provider on date:** ___________________

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. Intravenous Immune Globulin (IVIG) is approved by the OHSU P&T Committee for use in patients in whom there is literature/UHC/FDA documented effective uses. The OHSU Department of Pharmacy Services will reconstitute and prepare IVIG, rounding to the nearest 5 gram vial size to minimize wastage. Based on the supply and availability of products, Pharmacy has the authority to select the most cost effective IVIG product.
3. In patients who may be at risk of renal failure, a decrease in dose, rate, and/or concentration should be considered. IVIG should be given at a rate of less than 2 ml/kg/hr for the 10% solution. Avoid use in patients with CrCl less than 10 ml/min.
4. Ideal Body Weight (IBW) will be used to dose IVIG. Adjusted Body Weight will be used when a patient has an Actual Body Weight (ABW) greater than 130% IBW.
   a. IBW Males (kg) = 50 + (2.3 x (height in inches – 60))
   b. IBW Females (kg) = 45.5 + (2.3 x (height in inches – 60))
   c. If height < 60 inches, use 50 kg (male) and 45.5 kg (female) to calculate IBW
   d. Adjusted Body Weight= IBW + 0.4 (Actual Body Weight – IBW)

LABS: ***(must check to order)***

- ☐ Basic Metabolic Set, Routine, ONCE, every ______ (visit)(days)(weeks)(months) – *Circle One*
- ☐ IGG (serum), Routine, ONCE, every ______ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Labs already drawn. Date: ________

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)

Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

1. acetaminophen (TYLENOL) tablet, oral, ONCE, every visit
   - ☐ 650 mg
   - ☐ 325 mg
   - ☐ 500 mg
   - ☐ 1000 mg
2. diphenhydrAMINE (BENADRYL) capsule, oral, ONCE, every visit
   - ☐ 25 mg
   - ☐ 50 mg
3. loratadine (CLARITIN) tablet, oral, ONCE, every visit
   (Choose as alternative to diphenhydrAMINE if needed)
   - ☐ 10 mg
   - ☐ 5 mg

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MEDICATIONS:

Gammagard 10% (default brand):
(Pharmacist will round dose to nearest 5 gram vial and modify brand selection based upon availability during order verification)

- ☐ 0.2 g/kg = ______ g, intravenous, ONCE
- ☐ 0.4 g/kg = ______ g, intravenous, ONCE
- ☐ 0.5 g/kg = ______ g, intravenous, ONCE
- ☐ 1 g/kg = ________ g, intravenous, ONCE
- ☐ _________ g, intravenous, ONCE

Interval: ***(must check one)***

- ☐ Once
- ☐ Daily x _________ doses
- ☐ Every __________ weeks for _________ doses

Specifications:

- ☐ Patient requires a specific brand of IVIG (other than those listed above)
  Please specify here: ____
- ☐ Patient requires IVIG at a 5% concentration

Infuse per protocol. Decrease rate of infusion in patients who may be at risk of renal failure. Filtration is not necessary. Pharmacy will filter all preparations if required.

INFUSION GUIDELINES FOR 10% INTRAVENOUS IMMUNE GLOBULIN (Gammagard Liquid and Gamunex)

Patient Weight	RATE			
Kg	Minutes 0-30 (0.5 ml/kg/hr)* ML/HR	Minutes 31-60 (1 ml/kg/hr) ML/HR	Minutes 61-90 (2 ml/kg/hr) ML/HR	Minutes 91-120 (4 ml/kg/hr)** ML/HR
5	2.5	5	10	20
10	5	10	20	40
20	10	20	40	80
30	15	30	60	120
40	20	40	80	160
50	25	50	100	200
60	30	60	120	240
70	35	70	140	280
80	40	80	160	320
90	45	90	180	360
100	50	100	200	400

* Gamunex should be started at 0.6 ml/kg/hr
**Gammagard Liquid can be given up to the maximum rate of 5 ml/kg/hr if tolerated
Gamunex can be given up to the maximum rate 4.8 ml/kg/hr if tolerated

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NURSING ORDERS:

1. VITAL SIGNS – Assess vital signs before initiating IVIG infusion. During the first two infusions: assess vital signs at 15 minutes, 30 minutes, 1 hour, and then hourly for remainder of infusion. For subsequent infusions: if the patient has been stable without adverse reactions, the frequency of vital signs is discretionary.
2. IVIG Infusion Guidelines are available on the OHSU Pharmacy Services Intranet. See table for Infusion Guidelines. The rate of infusion may be increase only if no adverse reactions occur.
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction

AS NEEDED MEDICATIONS:

1. acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for fever
2. meperidine (DEMEROL) 25-50 mg, intravenous, EVERY 2 HOURS AS NEEDED for rigors in the absence of hypotension, Not to exceed 50 mg/hr

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ ________________ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _________________ <u>(MUST BE COMPLETED TO BE A VALID PRESCRIPTION)</u>; and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: ______________________________ Date/Time: _____________________

Printed Name:_____________________________ Phone: ________________ Fax:_____________

<u>OLC Central Intake Nurse:</u>

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

☐ **Beaverton**
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ **NW Portland**
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ **Gresham**
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ **Tualatin**
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders