ADULT AMBULATORY INFUSION ORDER
Intravenous Immune Globulin (IVIG)

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
**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)*

<table>
<thead>
<tr>
<th>Patient Weight</th>
<th>Minutes 0-30 (0.5 ml/kg/hr)*</th>
<th>Minutes 31-60 (1 ml/kg/hr)</th>
<th>Minutes 61-90 (2 ml/kg/hr)</th>
<th>Minutes 91-120 (4 ml/kg/hr)**</th>
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<td>400</td>
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* 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 4.0 ml/kg/hr if tolerated
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 increased 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 x1 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 # ________________ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); 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: ______________

OLC Central Intake Nurse:
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