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. Pharmacist to round dose to nearest whole vials. Pharmacist to order appropriate combination of vial sizes to administer total ordered dose. For doses that require more than one vial, orders should be prescribed as "once" order(s). For multiple consecutive days: Round dose to administer same dose each day, and set interval to "every visit" (for example, for dose of 70 grams over 2 days, order as 35 grams with "every visit" interval).
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. Adjusted Body Weight will be used when a patient has an Actual Body Weight (ABW) greater than 130% of Ideal Body Weight (IBW). Otherwise, IBW or ABW will be used, whichever is lowest.
    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)***

- ☐ CBC with Auto Differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Complete 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: _____

NURSING ORDERS:

1. VITAL SIGNS – Assess vital signs before initiating IVIG infusion, at each rate increase, and then hourly after reaching max rate.
2. IVIG Infusion Guidelines are available on MAR linked rate tables and the OHSU Pharmacy Services Intranet. The rate of infusion may be increased only if no adverse reactions occur. Start infusion at lowest rate per MAR linked rate table. If tolerated, increase gradually every 30 minutes to maximum rate per MAR linked rate table, maximum tolerated rate, or other maximum rate specified in table based on risk factors and indication (whichever is lowest). If infusion NOT tolerated, STOP infusion, follow appropriate hypersensitivity protocol.
3. Patient is at risk for renal dysfunction or thrombotic events? **Yes/No – *Must Circle One***
    a. For patients at risk for renal dysfunction or thrombotic events: MAX rates capped per product specific MAR linked rate table.

   b. Risk factors for renal dysfunction include (pre-existing renal insufficiency, age greater than 65, diabetes mellitus, volume depletion, or patients receiving known nephrotoxic drugs)
   c. Risk factors for thrombotic events include (prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling vascular catheters, hyperviscosity, and cardiovascular risk factors)
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

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)

- ☐ acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
- ☐ diphenhydrAMINE (BENADRYL) capsule, 50 mg, oral, ONCE, every visit
- ☐ loratadine (CLARITIN) tablet, 10 mg oral, ONCE AS NEEDED, every visit, if diphenhydramine is not given. ***(Choose as alternative to diphenhydrAMINE if needed)***

MEDICATIONS: (Select between Single-Day Dose or Multi-Day Split Dose)

INTRAVENOUS IMMUNE GLOBULIN:

- ○ **Gammagard 10% (OHSU & HMC preferred brand)**
- ○ **Gammagard ERC 10%**
- ○ **Privigen 10%**
- ○ **Gamunex-C 10%**

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

- ○ **Single Day Dose:**
  - ☐ 0.2 g/kg, ONCE
  - ☐ 0.4 g/kg, ONCE
  - ☐ 0.5 g/kg, ONCE
  - ☐ 1 g/kg, ONCE
  - ☐ _____ g, intravenous, ONCE

  Interval:
  - ☐ Once
  - ☐ Daily x _____ doses
  - ☐ Every _____ weeks for _____ doses
  - ☐ Other _____

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○ **Multi-Day Split Dose:**
- ☐ _____ g/kg (total dose) divided equally over _____ consecutive days
- ☐ _____ g (total dose) divided equally over _____ consecutive days

Interval:
- ☐ Once
- ☐ Every _____ weeks for _____ doses
- ☐ Other _____

Specifications:
- ☐ Patient requires a specific brand of IG (other than those listed above)
  Please specify here: _____
- ☐ Patient requires intravenous IG at a 5% concentration

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 (OHSU HC-PAT-133-GUD, HMC C-132). 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 x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.5 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
6. meperidine (PF) (DEMEROL) injection, 25-50 mg, intravenous, EVERY 2 HOURS AS NEEDED for infusion related severe 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:** _____

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Central Intake:

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