Spectrum Health Helen DeVos children's hospital

Physician's Orders IMMUNE GLOBULIN - PEDIATRIC, OUTPATIENT, INFUSION CENTER

Patient Name
DOB
MRN
Physician
FIN

Defaults for orders not otherwise specified below:
- ☐ Interval: Once
- ☐ Interval: Every 28 days
- ☐ Interval: Every 42 days
- ☐ Interval: Every 56 days
- ☐ Interval: Every 84 days
- ☐ Interval: Every ____ days

Duration:
- ☐ Once
- ☐ Until date: ___________
- ☐ 1 year
- ☐ ______# of Treatments

Anticipated Infusion Date_____________ ICD 10 Code with Description___________________________________

Height_____________(cm) Weight____________(kg) Allergies____

Provider Specialty

☐ Allergy/Immunology	☐ Infectious Disease	☐ OB/GYN	☐ Rheumatology
☐ Cardiology	☐ Internal Med/Family Practice	☐ Other	☐ Surgery
☐ Gastroenterology	☐ Nephrology	☐ Otolaryngology	☐ Urology
☐ Genetics	☐ Neurology	☐ Pulmonary	☐ Wound Care

Site of Service

☐ SH Gerber	☐ SH Lemmen Holton (GR)	☐ SH Pennock	☐ SH United Memorial
☐ SH Helen DeVos (GR)	☐ SH Ludington	☐ SH Reed City	☐ SH Zeeland

Appointment Requests

☑ Infusion Appointment Request
Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Labs and infusion

Provider Reminder

☑ ONC PROVIDER REMINDER
For symptoms of allergic reaction or anaphylaxis, order "Peds Hypersensitivity Reactions" Therapy Plan.

Labs

	Interval	Duration
☐ Complete Blood Count W/ Manual Differential STAT, Starting S, For 1 Occurrences, Blood, Venous	☐ Every ___days ☐ Once	☐ Until date: _______ ☐ 1 year ☐ ______# of Treatments
☐ Complete Blood Count w/Differential STAT, Starting S, For 1 Occurrences, Blood, Venous	☐ Every ___days ☐ Once	☐ Until date: _______ ☐ 1 year ☐ ______# of Treatments

Additional Lab Orders

	Interval	Duration
☐ Labs: ____	☐ Every ___days ☐ Once	☐ Until date: _______ ☐ 1 year ☐ ______# of Treatments
☐ Labs: ____	☐ Every ___days ☐ Once	☐ Until date: _______ ☐ 1 year ☐ ______# of Treatments

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NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.

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	Interval	Duration

Hypogammaglobulinemia, ITP & Rheumatology Only

Pre-Medications - Hypogammaglobulinemia, ITP & Rheumatology ONLY

Acetaminophen Premed-select Susp, Tab OR Chewable

☐ acetaminophen (TYLENOL) 32 MG/ML suspension 15 mg/kg
15 mg/kg, Oral, Every 6 hours, For 2 Doses
Give 30 minutes prior to infusion.
Recommended maximum single dose is 650 mg
No more than 5 doses from all sources in 24 hour period, not to exceed 4000 mg/day

☐ acetaminophen (TYLENOL) tablet 15 mg/kg
15 mg/kg, Oral, Every 6 hours, Starting S, For 2 Doses
Give 30 minutes prior to infusion.
Recommended maximum single dose is 650 mg
No more than 5 doses from all sources in 24 hour period, not to exceed 4000 mg/day

☐ acetaminophen (TYLENOL) dispersable / chewable tablet 15 mg/kg
15 mg/kg, Oral, Every 6 hours, Starting S, For 2 Doses
Give 30 minutes prior to infusion.
Recommended maximum single dose is 650 mg
No more than 5 doses from all sources in 24 hour period, not to exceed 4000 mg/day

Diphenhydramine Premed-select Cap, Liquid OR Injection

☐ diphenhydrAMINE (BENADRYL) capsule 1 mg/kg
1 mg/kg, Oral, Every 6 hours, Starting S, For 2 Doses
Give 30 minutes prior to infusion.
Recommended maximum single dose 50 mg

☐ diphenhydrAMINE (BENADRYL) 12.5 MG/5ML elixir 1 mg/kg
1 mg/kg, Oral, Every 6 hours, Starting S, For 2 Doses
Give 30 minutes prior to infusion.
Recommended maximum single dose 50 mg

☐ diphenhydrAMINE (BENADRYL) injection 1 mg/kg
1 mg/kg, Intravenous, Every 6 hours, Starting S, For 2 Doses
Give 30 minutes prior to infusion.
Recommended maximum single dose 50 mg

☐ **methylPREDNISolone sodium succinate (SOLU-Medrol) injection 1 mg/kg**
1 mg/kg, Intravenous, Administer over 15 Minutes, Starting S, For 1 Doses
Administer 30 minutes prior to infusion.
Recommended maximum single dose 80 mg

To reconstitute Act-O-Vial: Push top of vial to force diluent into lower compartment, then gently agitate. NON Act-O-Vials may be reconstituted with 2 mL of 0.9% sodium chloride for injection or bacteriostatic water for injection.

Dexamethasone Premed-select IV OR Oral Route

☐ dexamethasone (DECADRON) tablet 0.1 mg/kg
0.1 mg/kg, Oral, Once, Starting S, For 1 Doses
Administer 30 minutes prior to infusion.
Recommended maximum single dose 0.15 mg/kg

☐ dexamethasone (DECADRON) injection 0.1 mg/kg
0.1 mg/kg, Intravenous, Administer over 5 Minutes, Once, Starting S, For 1 Doses
Administer 30 minutes prior to infusion.
Recommended maximum single dose 0.15 mg/kg

☐ dexamethasone (DECADRON) injection 0.1 mg/kg
0.1 mg/kg, Oral, Once, Starting S, For 1 Doses
Administer 30 minutes prior to infusion.
Recommended maximum single dose 0.15 mg/kg

☑ **sodium chloride flush 0.9 % syringe 20 mL (FOR ITP**
20 mL, Intravenous, PRN, Line Care, Starting S, For 2 Doses
Administer IVIG in a separate infusion line from other medications. If using primary IV line, flush with Sodium Chloride 0.9% prior to and post IVIG infusion. Note: if IVIG dose is dispensed in a syringe, only flush with the volume of the tubing.

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Patient Name

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Additional Pre-Medications- Hypogammaglobulinemia, ITP & Rheumatology ONLY

☐ Pre-medication with dose: ______________________________

☐ Pre-medication with dose: ______________________________

Hypogammaglobulinemia

☐ immune globulin 10% (Privigen) infusion

Dose: Pharmacy can round within a 10% threshold to match vial size.

- ☐ 0.4 g/kg
- ☐ 0.5 g/kg
- ☐ 1 g/kg

Intravenous, Titrate, Starting S, For 1 Doses
Start infusion at 0.5 mL/kg/hour and if tolerated, may double infusion rate every 30 minutes, to a maximum rate of 1.6 mL/kg/hr. Do NOT infuse in less than 3 hours. Administer in separate infusion line from other medications. If using primary IV line, flush with sodium chloride 0.9% prior to and post IVIG infusion. Give IVIG 30 minutes AFTER pre-meds (i.e acetaminophen and diphenhydramine) if ordered.

ITP

☐ immune globulin 10% (Privigen) infusion

Dose: Pharmacy can round within a 10% threshold to match vial size.

- ☐ 0.5 g/kg
- ☐ 1 g/kg

Intravenous, Titrate, Starting S, For 1 Doses

For ITP patients infuse over 4-10 hours. Start infusion at 0.5 mL/kg/hour and if tolerated, may double infusion rate every 30 minutes, to a maximum rate of 1.4 mL/kg/hr. Do NOT infuse in less than 4 hours. Administer in separate infusion line from other medications. If using primary IV line, flush with sodium chloride 0.9% prior to and post IVIG infusion. Give IVIG 30 minutes AFTER pre-meds (i.e acetaminophen and diphenhydramine) if ordered.

Rheumatology

☐ immune globulin 10% (Privigen) infusion

Dose: Pharmacy can round within a 10% threshold to match vial size.

- ☑ 0.5 mg/kg

Intravenous, Titrate, Starting S, For 1 Doses
Start infusion at 0.5 mL/kg/hour and if tolerated, may double infusion rate every 30 minutes, to a maximum rate of 2 mL/kg/hr. Do NOT infuse in less than 3 hours. Administer in separate infusion line from other medications. If using primary IV line, flush with sodium chloride 0.9% prior to and post IVIG infusion. Give IVIG 30 minutes AFTER pre-meds (i.e acetaminophen and diphenhydramine) if ordered.

Nursing Orders – Hypogammaglobulinemia, ITP, Rheumatology ONLY

☑ ONC NURSING COMMUNICATION 1

- Monitor vital signs with pulse oximetry every 15 minutes until the maximum delivery rate is reached then hourly x 2, then every 2 hours x 2 then every 4 hours until complete

- Notify provider if O2 saturation is less than or equal to 92%

- For signs of infusion reaction: fever, chills, dyspnea, urticaria, headache, muscle aches. STOP infusion and notify provider. For resumption of infusion after reaction, restart IVIG at 50% of reaction rate if reaction signs and symptoms subside and physician has verified permission to restart.

- Verify that patient has diphenhydramine / Epi-pen available (as appropriate) for immediate home use. Advise patient that severe hypersensitivity or anaphylactic reactions may occur during and after infusion. Inform patients of signs and symptoms of anaphylaxis and hypersensitivity reactions, and importance of seeking medical care.

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Patient Name
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BMT ONLY

Pre-Medications – BMT ONLY

☑ **Acetaminophen Premed-select Susp, Tab OR Chewable**

☐ acetaminophen (TYLENOL) 32 MG/ML suspension 15 mg/kg
15 mg/kg, Oral, Every 6 hours, For 2 Doses
Give 30 minutes prior to infusion.
Recommended maximum single dose is 650 mg
No more than 5 doses from all sources in 24 hour period, not to exceed 4000 mg/day

☐ acetaminophen (TYLENOL) tablet 15 mg/kg
15 mg/kg, Oral, Every 6 hours, Starting S, For 2 Doses
Give 30 minutes prior to infusion.
Recommended maximum single dose is 650 mg
No more than 5 doses from all sources in 24 hour period, not to exceed 4000 mg/day

☐ acetaminophen (TYLENOL) dispersable / chewable tablet 15 mg/kg
15 mg/kg, Oral, Every 6 hours, Starting S, For 2 Doses
Give 30 minutes prior to infusion.
Recommended maximum single dose is 650 mg
No more than 5 doses from all sources in 24 hour period, not to exceed 4000 mg/day

☑ **Diphenhydramine Premed-select Cap, Liquid OR Injection**

☐ diphenhydrAMINE (BENADRYL) capsule 1 mg/kg
1 mg/kg, Oral, Every 6 hours, Starting S, For 2 Doses
Give 30 minutes prior to infusion.
Recommended maximum single dose 50 mg

☐ diphenhydrAMINE (BENADRYL) 12.5 MG/5ML elixir 1 mg/kg
1 mg/kg, Oral, Every 6 hours, Starting S, For 2 Doses
Give 30 minutes prior to infusion.
Recommended maximum single dose 50 mg

☐ diphenhydrAMINE (BENADRYL) injection 1 mg/kg
1 mg/kg, Intravenous, Every 6 hours, Starting S, For 2 Doses
Give 30 minutes prior to infusion.
Recommended maximum single dose 50 mg

☑ **methylPREDNISolone sodium succinate (SOLU-Medrol) injection 1 mg/kg**
1 mg/kg, Intravenous, Administer over 15 Minutes, Starting S, For 1 Doses
Administer 30 minutes prior to infusion.
Recommended maximum single dose 80 mg
To reconstitute Act-O-Vial: Push top of vial to force diluent into lower compartment, then gently agitate. NON Act-O-Vials may be reconstituted with 2 mL of 0.9% sodium chloride for injection or bacteriostatic water for injection.

☑ **Dexamethasone Premed-select IV OR Oral Route**

☐ dexamethasone (DECADRON) tablet 0.1 mg/kg
0.1 mg/kg, Oral, Once, Starting S, For 1 Doses
Administer 30 minutes prior to infusion.
Recommended maximum single dose 0.15 mg/kg

☐ dexamethasone (DECADRON) injection 0.1 mg/kg
0.1 mg/kg, Intravenous, Administer over 5 Minutes, Once, Starting S, For 1 Doses
Administer 30 minutes prior to infusion.
Recommended maximum single dose 0.15 mg/kg

☐ dexamethasone (DECADRON) injection 0.1 mg/kg
0.1 mg/kg, Oral, Once, Starting S, For 1 Doses
Administer 30 minutes prior to infusion.
Recommended maximum single dose 0.15 mg/kg

Additional Pre-Medications – BMT Only

☐ Pre-medication with dose: ______________________________

☐ Pre-medication with dose: ______________________________

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Patient Name
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BMT

Select Immune Globulin 5% (low Iga) Or 10%

☐ immune globulin 10% (Privigen) infusion

Dose: Pharmacy can round within a 10% threshold to match vial size.

- ☐ 0.4 g/kg
- ☐ 0.5 g/kg
- ☐ 1 g/kg
- ☐ ____ g/kg

Treatment Indication:

- ☐ ITP-Peds and Adult
- ☐ Heart Transplant: Severe Rejection- Hemodynamic Compromise
- ☐ Heart/Lung Transplant: Antibody Mediated Rejection
- ☐ Heart/Lung Transplant: Desensitization
- ☐ Lunt Transplant: Donor Specific-Anti-HLA Antibody Treatment
- ☐ Lung Transplant: Respiratory Syncytial Virus
- ☐ Hematopoietic Cell Transplant-Peds and Adult
- ☐ Adult Neurologic Conditions
- ☐ Streptococcal Toxic Shock Syndrome
- ☐ Primary Immunodeficiency or low IgG-Peds and Adult
- ☐ Kawasaki Disease
- ☐ Pediatric Myocarditis
- ☐ Pediatric Rheumatologic Conditions
- ☐ Pediatric Neurologic Conditions
- ☐ Neonatal Indirect Hyperbilirubinemia
- ☐ Other: ____

Intravenous, Titrate, Starting S, For 1 Doses
For BMT patients, start infusion at 0.5 mL/kg/hr and if tolerated, may double infusion rate every 30 minutes, to a maximum rate of 1.6 mL/kg/hr. Do NOT infuse in less than 3 hours. Administer in separate infusion line from other medications. If using primary IV line, flush with sodium chloride 0.9% prior to and post IVIG infusion. Give IVIG 30 minutes AFTER pre-meds (i.e acetaminophen and diphenhydramine) if ordered.

☐ immune globulin LOW IGA 5% (GAMMAGARD S/D) infusion

Dose: Pharmacy can round within a 10% threshold to match vial size.

- ☐ 0.4 g/kg
- ☐ 0.5 g/kg
- ☐ 1 g/kg
- ☐ ____ g/kg

Treatment Indication:

- ☐ ITP-Peds and Adult
- ☐ Heart Transplant: Severe Rejection- Hemodynamic Compromise
- ☐ Heart/Lung Transplant: Antibody Mediated Rejection
- ☐ Heart/Lung Transplant: Desensitization
- ☐ Lunt Transplant: Donor Specific-Anti-HLA Antibody Treatment
- ☐ Lung Transplant: Respiratory Syncytial Virus
- ☐ Hematopoietic Cell Transplant-Peds and Adult
- ☐ Adult Neurologic Conditions
- ☐ Streptococcal Toxic Shock Syndrome
- ☐ Primary Immunodeficiency or low IgG-Peds and Adult
- ☐ Kawasaki Disease
- ☐ Pediatric Myocarditis
- ☐ Pediatric Rheumatologic Conditions
- ☐ Pediatric Neurologic Conditions
- ☐ Neonatal Indirect Hyperbilirubinemia
- ☐ Other: ____

Intravenous, Titrate, Starting S, For 1 Doses
For BMT patients, start infusion at 0.5 mL/kg/hr and if tolerated, may double infusion rate every 30 minutes, to a maximum rate of 1.6 mL/kg/hr. Do NOT infuse in less than 3 hours. Administer in separate infusion line from other medications. If using primary IV line, flush with sodium chloride 0.9% prior to and post IVIG infusion. Give IVIG 30 minutes AFTER pre-meds (i.e acetaminophen and diphenhydramine) if ordered.

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DOB
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BMT

Nursing Orders – BMT ONLY

☑ ONC NURSING COMMUNICATION 15

For Heme/Onc BMT patients, the IVIG infusion duration should be a minimum of 3 hours. Do NOT titrate to maximum infusion rate on Drug Quick Reference.

☑ ONC NURSING COMMUNICATION 1

- Monitor vital signs with pulse oximetry every 15 minutes until the maximum delivery rate is reached then hourly x 2, then every 2 hours x 2 then every 4 hours until complete

- Notify provider if O2 saturation is less than or equal to 92%

- For signs of infusion reaction: fever, chills, dyspnea, urticaria, headache, muscle aches. STOP infusion and notify provider. For resumption of infusion after reaction, restart IVIG at 50% of reaction rate if reaction signs and symptoms subside and physician has verified permission to restart.

- Verify that patient has diphenhydramine / Epi-pen available (as appropriate) for immediate home use. Advise patient that severe hypersensitivity or anaphylactic reactions may occur during and after infusion. Inform patients of signs and symptoms of anaphylaxis and hypersensitivity reactions, and importance of seeking medical care.

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Telephone order/Verbal order documented and read-back completed. Practitioner's initials ______

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED: TIME DATE	VALIDATED: TIME DATE	ORDERED: TIME DATE	Pager #
Sign	R.N. Sign	Physician Print	Physician

EPIC VERSION DATE: 07/16/20

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