Corewell Health™

Patient Name
DOB
MRN
Physician
CSN

Physician's Orders
IMMUNE GLOBULIN, INTRAVENOUS (IV) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER

Defaults for orders not otherwise specified below:
- ☐ Once
- ☐ Interval: Every 14 days
- ☐ Interval: Every 21 days
- ☐ Interval: Every 28 days
- ☐ Interval: Every___days

Duration:
- ☐ Until date: _____
- ☐ 1 year
- ☐ _____# of Treatments

Anticipated Infusion Date_____ICD 10 Code with Description_____

Height_____(cm) Weight_____(kg) Allergies_____

Site of Service

☐ CH Blodgett (GR)	☐ CH Helen DeVos (GR)	☐ CH Ludington	☐ CH Reed City
☐ CH Gerber	☐ CH Lemmen Holton (GR)	☐ CH Pennock	☐ CH Zeeland
☐ CH Greenville			

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

Appointment Requests

☑ Infusion Appointment Request
Status: Future, Expected: S, Expires: S+366, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion and possible labs

Provider Ordering Guidelines

☑ ONC PROVIDER REMINDER 10
IMMUNE GLOBULIN INTRAVENOUS HUMAN (IVIG):

For actual body weight greater than or equal to IBW (non-underweight patients), initially dose IVIG using IBW. For actual body weight less than IBW (underweight patients), initially dose IVIG using actual body weight.

Round IVIG doses to the nearest 5 gm (vial size).

Labs

☐ IgG, Blood Level
Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous

☐ Lab:_____
- ☐ 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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IMMUNE GLOBULIN, INTRAVENOUS (IV) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER *(CONTINUED)*

Nursing Orders

☑ ONC NURSING COMMUNICATION 11

IMMUNE GLOBULIN INTRAVENOUS HUMAN (IVIG):
If mild reactions occur (headache, flushing, dizziness, nausea, chills, mild hypotension): Temporarily stop or slow infusion rate. Notify ordering physician/NP/PA. If symptoms subside promptly, the infusion may be resumed at a lower rate (that does not result in recurrence of the symptoms).

For severe reactions (including anaphylaxis): Discontinue IVIG and notify ordering physician/NP/PA.

Monitor patient vital signs throughout the infusion. Slow or stop infusion if adverse reactions occur. If symptoms subside promptly, the infusion may be resumed at a lower rate that is comfortable for the patient. Certain severe adverse drug reactions may be related to the rate of infusion. Slowing or stopping the infusion usually allows the symptoms to disappear promptly.

☑ ONC NURSING COMMUNICATION 100

May Initiate IV Catheter Patency Adult Protocol

☑ Hypersensitivity Reaction Adult Oncology Protocol

Routine, Until discontinued Starting when released for 24 hours
HYPERSENSITIVITY REACTIONS:
Discontinue the medication infusion immediately.

Activate emergency response for severe or rapidly progressing symptoms. Where available consider calling RAP and have crash cart available. Call 911 or code team (if applicable) as needed for an absence of pulse and respirations. Refer to site specific emergency response policy.

Stay with patient until symptoms have resolved.

Initiate/Continue Oxygen to maintain SpO2 greater than 90% and discontinue Oxygen Therapy to maintain SpO2 above 90%

For severe or rapidly progressing hypersensitivity reaction symptoms, monitor vital signs and pulse oximeter readings every 2 to 5 minutes until the patient is stable and symptoms resolve.

Document medication infusing and approximate dose received at time of reaction in the patient medical record. Document allergy to medication attributed with causing reaction in patient medical record. Complete Adverse Drug Reaction form per Pharmacy Clinical Policy.

Pre-Medications

☑ acetaminophen (TYLENOL) tablet 650 mg
650 mg, Oral, Once, Starting S, For 1 Doses

☑ diphenhydrAMINE (BENADRYL) capsule 25 mg
25 mg, Oral, Once, Starting S, For 1 Doses

☐ ondansetron (ZOFRAN) injection 4 mg
4 mg, Intravenous, Administer over 5 Minutes (24 ml/hr), Once, Starting S, For 1 Doses

☐ furosemide (LASIX) injection 20 mg
20 mg, Intravenous, Administer 2 Minutes, Once, Starting S, For 1 Doses

☐ methylPREDNISolone sodium succinate (SOLU-Medrol) injection
- ☐ 40 mg IVP
- ☐ 70 mg IVP
- ☐ 125 mg IVP
- ☐ 250 mg, Intravenous, Administer over 30 minutes
- ☐ 500 mg, Intravenous, Administer over 30 minutes
- ☐ 1000 mg, Intravenous, Administer over 30 minutes

Unscheduled, Starting S, For 1 Doses

Administer 30 minutes before infusion

☐ Pre-medication with dose:

_____

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IMMUNE GLOBULIN, INTRAVENOUS (IV) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER *(CONTINUED)*

Page 3 to 6

Medications (pages 3 – 6)

☑ **Immune Globulin 10% (Privigen Or Gamunex Or Gammagard) Or Immune Globulin 5% (low Iga) Infusion**

☑ immune globulin 10% (human) (PRIVIGEN) infusion
(PREFERRED FORMULARY)
Intravenous, Titrate, Starting S+30 Minutes, For 1 Doses

☐ 0.4 g/kg
☐ 0.5 g/kg
☐ 1 g/kg
☐ 2 g/kg

Start infusion at 0.3 mL/kg/hour and if tolerated, may double infusion rate every 30 minutes, to a maximum rate of 4.8 mL/kg/hr (or to a PROVIDER specified maximum rate (mL/kg/hr) in selected patients; SEE BELOW).

USE STANDARD MAX INFUSION RATE? 4.8 mL/kg/hr should be used. [Patient has NO risk factors; patient NOT at risk for cardiac or pulmonary fluid overload, renal dysfunction, thrombosis, being treated for Kawasaki, chronic ITP or s/p transplant]:

☐ Yes
☐ No

If NO, indicate PROVIDER SPECIFIED RATE – PATIENT WITH RISK FACTOR OR INTOLERANCE? – risk for cardiac or pulmonary fluid overload, renal dysfunction, thrombosis or those being treated for Kawasaki Disease (2 g/kg/dose) or chronic idiopathic thrombocytopenic purpura (ITP)

☐ 2 mL/kg/hr (Standard)
☐ 1 mL/kg/hr
☐ Other: _____

Reason/Indication for reduced maximum immune globulin (IVIG) infusion rate

☐ Risk for renal dysfunction
☐ Risk for thrombosis
☐ Kawasaki Disease
☐ Chronic immune idiopathic thrombocytopenic purpura (ITP)
☐ Transplant patient
☐ Cardiovascular disease: _____
☐ Pulmonary disease
☐ Other: _____

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IMMUNE GLOBULIN, INTRAVENOUS (IV) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER *(CONTINUED)*

☐ immune globulin (human) 10% (GAMUNEX-C) infusion
Intravenous, Titrate, Starting S+30 Minutes, For 1 Doses

☐ 0.4 g/kg
☐ 0.5 g/kg
☐ 1 g/kg
☐ 2 g/kg

Start infusion at 0.5 mL/kg/hour and, if tolerated, may double infusion rate every 30 minutes, to a maximum rate of 4.8 mL/kg/hr (or to a PROVIDER specified maximum rate (mL/kg/hr) in selected patients; SEE BELOW).

USE STANDARD MAX INFUSION RATE? 4.8 mL/kg/hr should be used. [Patient has NO risk factors; patient NOT at risk for cardiac or pulmonary fluid overload, renal dysfunction, thrombosis, being treated for Kawasaki, chronic ITP or s/p transplant]:

☐ Yes
☐ No

If NO, indicate PROVIDER SPECIFIED RATE – PATIENT WITH RISK FACTOR OR INTOLERANCE? – risk for cardiac or pulmonary fluid overload, renal dysfunction, thrombosis or those being treated for Kawasaki Disease (2 g/kg/dose) or chronic idiopathic thrombocytopenic purpura (ITP)

☐ 2 mL/kg/hr (Standard)
☐ 1 mL/kg/hr
☐ Other: _____

Reason/Indication for reduced maximum immune globulin (IVIG) infusion rate

☐ Risk for renal dysfunction
☐ Risk for thrombosis
☐ Kawasaki Disease
☐ Chronic immune idiopathic thrombocytopenic purpura (ITP)
☐ Transplant patient
☐ Cardiovascular disease: _____
☐ Pulmonary disease
☐ Other: _____

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IMMUNE GLOBULIN, INTRAVENOUS (IV) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER *(CONTINUED)*

☐ immune globulin 10% (human) (GAMMAGARD) infusion
Intravenous, Titrate, Starting S+30 Minutes, For 1 Doses

☐ 0.4 g/kg
☐ 0.5 g/kg
☐ 1 g/kg
☐ 2 g/kg

Start infusion at 0.5 mL/kg/hour and if tolerated, may double infusion rate every 30 minutes, to a maximum rate of 4.8 mL/kg/hr (or to a PROVIDER specified maximum rate (mL/kg/hr) in selected patients; SEE BELOW).

USE STANDARD MAX INFUSION RATE? 4.8 mL/kg/hr should be used. [Patient has NO risk factors; patient NOT at risk for cardiac or pulmonary fluid overload, renal dysfunction, thrombosis, being treated for Kawasaki, chronic ITP or s/p transplant]:

☐ Yes
☐ No

If NO, indicate PROVIDER SPECIFIED RATE – PATIENT WITH RISK FACTOR OR INTOLERANCE? – risk for cardiac or pulmonary fluid overload, renal dysfunction, thrombosis or those being treated for Kawasaki Disease (2 g/kg/dose) or chronic idiopathic thrombocytopenic purpura (ITP)

☐ 2 mL/kg/hr (Standard)
☐ 1 mL/kg/hr
☐ Other: _____

Reason/Indication for reduced maximum immune globulin (IVIG) infusion rate

☐ Risk for renal dysfunction
☐ Risk for thrombosis
☐ Kawasaki Disease
☐ Chronic immune idiopathic thrombocytopenic purpura (ITP)
☐ Transplant patient
☐ Cardiovascular disease: _____
☐ Pulmonary disease
☐ Other: _____

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IMMUNE GLOBULIN, INTRAVENOUS (IV) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER *(CONTINUED)*

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

Intravenous, Titrate, Starting S+30 Minutes, For 1 Doses

☐ 0.4 g/kg
☐ 0.5 g/kg
☐ 1 g/kg
☐ 2 g/kg

Start infusion at 0.5 mL/kg/hour and if tolerated, may double infusion rate every 30 minutes, to a maximum rate of 4.8 mL/kg/hr (or to a PROVIDER specified maximum rate (mL/kg/hr) in selected patients; SEE BELOW).

USE STANDARD MAX INFUSION RATE? 4.8 mL/kg/hr should be used. [Patient has NO risk factors; patient NOT at risk for cardiac or pulmonary fluid overload, renal dysfunction, thrombosis, being treated for Kawasaki, chronic ITP or s/p transplant]:

☐ Yes
☐ No

If NO, indicate PROVIDER SPECIFIED RATE – PATIENT WITH RISK FACTOR OR INTOLERANCE? – risk for cardiac or pulmonary fluid overload, renal dysfunction, thrombosis or those being treated for Kawasaki Disease (2 g/kg/dose) or chronic idiopathic thrombocytopenic purpura (ITP)

☐ 2 mL/kg/hr (Standard)
☐ 1 mL/kg/hr
☐ Other: _____

Reason/Indication for reduced maximum immune globulin (IVIG) infusion rate

☐ Risk for renal dysfunction
☐ Risk for thrombosis
☐ Kawasaki Disease
☐ Chronic immune idiopathic thrombocytopenic purpura (ITP)
☐ Transplant patient
☐ Cardiovascular disease: _____
☐ Pulmonary disease
☐ Other: _____

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

EPIC VERSION DATE: 12/14/23

