Spectrum Health

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

Patient Name
DOB
MRN
Physician
FIN

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_____

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+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

CONTINUED ON PAGE 2 ➔

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

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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

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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Patient Name

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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:

CONTINUED ON PAGE 4 ➔

Patient Name

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☐ 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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Patient Name

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☐ 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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Patient Name

DOB

MRN

Physician

FIN

☐ 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**

EPIC VERSION DATE: 07/16/21

