Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO9031

ADULT AMBULATORY INFUSION ORDER

Immune Globulin (IVIG) Infusion

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 the OHSU Pharmacy Services Intranet. See table for Infusion Guidelines. The rate of infusion may be increase only if no adverse reactions occur. Adventist follows package insert guidelines.
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

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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:

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

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

- ☐ 0.2 g/kg, intravenous, ONCE
- ☐ 0.4 g/kg, intravenous, ONCE
- ☐ 0.5 g/kg, intravenous, ONCE
- ☐ 1 g/kg, 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

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, 0.3 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

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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:** _____

Please check the appropriate box for the patient's preferred clinic location:

☐ **Hillsboro Medical Center**
Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ **Adventist Health Portland**
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756

☐ **Mid-Columbia Medical Center**
Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610