LIFEBRIDGE HEALTH
CARE BRAVELY

INTRAVENOUS IMMUNOGLOBULIN (IVIG) ORDER FORM

Patient Label

Patient Name: _____ DOB: _____

Diagnosis: _____ Diagnosis Code: _____ Height: _____

Allergies: _____ Weight: _____

Pre-appointment Documentation:

Please fax most recent office visit note documenting the patient's diagnosis, a copy of the lab results below, as well as a copy of the patient's demographic information along with this order form.

DOSE BASED ON IDEAL BODY WEIGHT (IBW):

$$IBW\ (kg)\ males\ =\ (height\ (in) - 60in)\ x\ 2.3kg + 50kg$$

$$IBW\ (kg)\ females\ =\ (height\ (in) - 60in)\ x\ 2.3kg + 45.5kg$$

Treatment Orders:

Premedication(s) – *please check all premedication(s) desired for treatment*

- ☐ Acetaminophen 650mg PO once
- ☐ Diphenhydramine **25mg** or **50mg** **PO** or **IV** once *(will use 25mg PO if dose/route not indicated)*
- ☐ Famotidine 20mg IVP once
- ☐ Methylprednisolone 125mg IVP once
- ☐ Normal saline 500mL, IV over 1 hour
- ☐ Other: _____

IVIG infusion – Privigen 10% ***(***dose will be rounded to nearest 10 grams***)***

- ☐ 0.4gm/kg/day = _____ gm/day x _____ days every _____ weeks
- ☐ 0.5gm/kg/day = _____ gm/day x _____ days every _____ weeks
- ☐ Other: _____ gm/kg/day = _____ gm/day x _____ days every _____ weeks

Duration of Therapy: _____ *(will assume a one-time order unless duration is specified)*

Post-infusion order(s)

- ☐ Normal saline 500mL, IV over 1 hour
- ☐ Heparin 500units/mL 5mL port flush upon completion of infusion
- ☐ Other: _____

Lab Orders:

- ☐ Serum creatinine and BUN day 1 of every cycle
- ☐ Other: _____

☒ **Hypersensitivity/Anaphylaxis Medications and Extravasation Management (PRN):** Follow Adult Hypersensitivity Protocol as needed per Nursing Protocol for the treatment of allergic/hypersensitivity reaction. Follow established hospital protocol for extravasation.

Physician's Name (Print): _____ Signature: _____ Date: _____

Contact Number: _____ Fax Number: _____

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