LIFEBRIDGE HEALTH
CARE BRAVELY

INTRAVENOUS IMMUNOGLOBULIN (IVIG) ORDER FORM

Patient Name: _____ DOB: _____

Allergies: _____ Height (cm) : _____ Weight (kg) : _____

Diagnosis: _____ Diagnosis Code: _____

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Financial authorizations require clinical documentation of medical necessity. To ensure compliance, the criteria below must be indicated as completed by office representative. Incomplete documentation will be returned to the referring office for completion, resulting in delays to the patient receiving treatment.

- ☐ Ordering provider is credentialed at Sinai Hospital (Alvin and Lois Lapidus Cancer Center) or Carroll Hospital (William E. Kahlert Regional Cancer Center) to admit and write orders.
- ☐ Demographics / insurance information attached, or available in Cerner.
- ☐ Provider note dated within 30 days indicating medical need attached, or date if available in Cerner: _____

Lab Orders:

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

Treatment:

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

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

IVIG infusion – Privigen 10% *(*dose will be based on ideal body weight and rounded to nearest 10 grams***)***

- ☐ 0.4 gm/kg/day: _____ gm/day IV x _____ days every _____ weeks, infusion rate per titration protocol
- ☐ 0.5 gm/kg/day: _____ gm/day IV x _____ days every _____ weeks, infusion rate per titration protocol
- ☐ Other: _____ gm/kg/day = _____ gm/day x _____ days every _____ weeks, infusion rate per titration protocol

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

Privigen titration protocol: Start infusion at 0.3 mL/kg/hr x 30 minutes, double infusion rate every 30 minutes as tolerated to a maximum rate of 2.4 mL/kg/hr.

Post-infusion order(s)

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

Protocol Orders:

- ☒ Hypersensitivity/Anaphylaxis Medications**:** Follow Adult Hypersensitivity Nursing Protocol PRN for the treatment of allergic/hypersensitivity reaction.
- ☒ Extravasation Management: Follow established protocol for extravasation as needed.
- ☒ Port Care and Flush per Nursing Protocol: Single-lumen flush protocol or double-lumen flush protocol as appropriate.

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

Contact Number: _____ Fax Number: _____

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