

## Intravenous Immune Globulin (IVIG) Orders

**Fax all pages to (855) 270-7347**

### Patient Information

Order Date:	Requested Start of Care Date:	Date of Birth:
Patient name:	Height:	Weight: lb / kg
Address:	City:	State: Zip:
IV Access: <input type="radio"/> Peripheral <input type="radio"/> Port <input type="radio"/> Other:		
Primary Diagnosis:		ICD-10:
Secondary Diagnosis:		ICD-10:
Allergies:		

### IVIG Orders

<b>LOADING DOSE (if needed):</b> ____ gm OR ____ gm / kg	<b>MAINTENANCE DOSE:</b> ____ gm OR ____ gm / kg
<b>DIRECTIONS:</b>	<b>DIRECTIONS:</b> <input type="checkbox"/> once daily for ____ days <input type="checkbox"/> other: _____ Repeat course every ____ <input type="radio"/> weeks <input type="radio"/> months or _____ for a total of ____ courses (+/- ____ days for scheduling flexibility)

- Brand: \_\_\_\_\_ (pharmacy to select brand and/or concentration unless otherwise specified)
- Multiple day courses to be infused on *consecutive* days unless checked:  
 consecutive or non-consecutive days  non-consecutive days only  If ordered consecutively, may omit weekends
- Round dose to nearest 5 gm vial (nearest available vial size if weight ≤40 lbs.) or per payer requirement Decline
- Pharmacist to adjust dose ordered in gm/kg if weight changes +/- 10% Decline
- Titrate per Nufactor guidelines as tolerated unless ordered otherwise.

- Refill \_\_\_\_ months (Unless noted, prescriptions valid 1 year from date signed.)
- Dispense size(s) and quantity sufficient

### Premedication Orders / Other Orders

Patient Type	Drug	Description / Dispense Quantity Sufficient	Dose	Route / Frequency	Decline
Adult & Pediatric ≥12 years (if not at least 95 lb., follow <12 years dosing)	Acetaminophen	325 mg tab or 160 mg/5 ml oral 120 ml	325 - 650 mg	Orally pre-Ig prn. May repeat q 4 - 6 hr prn. Max 3 gm/day.	Decline <input type="checkbox"/>
Pediatric 0 - 11 years		160 mg/5 ml oral 120 ml	10 mg/kg (round to nearest 1/4 tsp)		
Adult	Diphenhydramine	25 mg tab or 12.5 mg/5 ml oral 120 ml	25 - 50 mg	Orally pre-Ig prn. May repeat q 4 - 6 hr prn.	Decline <input type="checkbox"/>
Pediatric ≥ 12 years		12.5 mg/5 ml oral 120 ml	25 mg		
Pediatric 6 - 11 years		12.5 mg/5 ml oral 120 ml	12.5 - 25 mg		
Pediatric 2 - 5 years		12.5 mg/5 ml oral 120 ml	6.25 mg		
Adult & Pediatric ≥6 years	Loratadine (if excessive drowsiness from diphenhydramine)	10 mg tab or 5 mg/5 ml oral 120 ml	10 mg	Orally pre-Ig prn. No repeat.	Decline <input type="checkbox"/>
Pediatric 2 - 5 years		5 mg/5 ml oral 120 ml	5 mg		

OTHER

### Lab Orders

BUN/Scr with first course if none available within 6 months. <input type="checkbox"/> decline	BUN/Scr annually. <input type="checkbox"/> decline
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## Intravenous Immune Globulin (IVIG) Orders

Patient Name:					
Anaphylaxis Orders					
Patient Type	Drug	Description / Dispense Quantity Sufficient	*Reaction Severity	Dose	Route/Frequency
Adult	Diphenhydramine	25 mg tab #24 or 12.5 mg/5 ml oral 120 ml	Mild or severe	50 mg	Orally every 6 hr as needed.
Pediatric		12.5 mg/5 ml oral 120 ml		1.25 mg/kg (max 50 mg)	
Adult & Pediatric >66 lbs	Epinephrine	0.3 mg Auto-Injector #2 or 1 mg/ml 1 ml vial/amp #2	Severe	0.3 mg	IM (auto-injector) or SubQ (vial/amp) x 1 dose. May repeat in 5 – 15 minutes as needed.
Pediatric 33 - 66 lbs		0.15 mg Auto-Injector #2 or 1 mg/ml 1 ml vial/amp #2		0.15 mg	
Pediatric <33 lbs		1 mg/ml 1 ml vial/amp #2		0.01 mg/kg	
Adult and Pediatric	Sodium chloride 0.9%	250 ml IV Bag #1	Severe	250 ml	Stop causative drug, then administer IV at KVO rate.
*Mild allergic reactions include itching, hives, rash, nausea and/or vomiting					
*Severe anaphylaxis reactions include angioedema, wheezing, difficulty breathing, swelling of eyelids or lips					
Other Orders:					
IV Access Maintenance (Dispense quantity sufficient)					
Venous Access	Patient Type	NS 10 ml syringe pre/post use	NS 10 ml syringe post blood draw	Heparin 5 ml syringe post last NS	Lidocaine/prilocaine 2.5%/2.5% cream
Peripheral	Adult/Pedi > 15 kg	1 - 3 ml	n/a	10 units/ml: 1 - 3 ml <sup>2</sup>	Apply topically 60 minutes prior to needle insertion prn discomfort.
	Pedi ≤ 15 kg	1 - 3 ml	n/a	10 units/ml: 1 ml <sup>2</sup>	
Midline, Central (non-port), PICC <sup>1</sup>	Adult/Pedi > 15 kg	3 - 5 ml	5 - 10 ml	10 units/ml: 3 - 5 ml <sup>2</sup>	
	Pedi ≤ 15 kg	3 ml	3 ml	10 units/ml: 3 ml <sup>2</sup>	
Implanted Port <sup>1</sup>	Adult/Pedi > 15 kg	5 - 10 ml	10 - 20 ml	100 units/ml: 5 ml <sup>3</sup>	
	Pedi ≤ 15 kg	3 - 5 ml	5 ml	10 units/ml: 5 ml <sup>3</sup>	
Groshong PICC/Midline <sup>1</sup>	Adult/Pedi > 15 kg	5 - 10 ml <sup>4</sup>	10 - 20 ml	None	
	Pedi ≤ 15 kg	3 - 5 ml <sup>4</sup>	3 - 5 ml	None	
<sup>1</sup> Follow manufacturer-specific recommendations if different.					
Maintenance flush when not in use: <sup>2</sup> daily, <sup>3</sup> daily if accessed; monthly if de-accessed, <sup>4</sup> daily to weekly					
Ancillary Supplies and DME Orders (Dispense quantity sufficient)					
Ancillary supplies, including a disposable IV pole, for the infusion of IVIG via peripheral IV, port, or indwelling central catheter via gravity or by ambulatory infusion pump. For Medicare B: services, supplies & accessories used in the home, per infusion (Q2052).					
Nursing Orders					
<ul style="list-style-type: none"> <li>Nurse to obtain IV access via placement of peripheral IV or insertion of port needle when applicable. If IV access is not obtained after 3 attempts, nurse should contact Nufactor for assistance.</li> <li>Nurse to administer IVIG and ancillary medications per physician orders.</li> </ul>			<ul style="list-style-type: none"> <li>Nurse to remove peripheral IV catheter after completion of infusion. If peripheral IV, may leave in place up to 5 days as long as no erythema or edema. If port, may leave access device in place up to 7 days. If PICC, change dressing weekly. Nurse to monitor for signs/symptoms of infection/infiltration.</li> </ul>		
Physician Information					
Signature:			Name:		
			NPI#:		
			Address:		
Date:			Phone:		Fax:

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