IVIG (Intravenous Immunoglobulin 10%)

Infusion Order Form – Page 1 of 2

Preferred Clinic Location

☐ **Harbor Health Park Bend Clinic**
2200 Park Bend Drive, Bldg. 2, Suite 204, Austin, TX 78758
P: (512) 270-2104
F: (512) 233-2288

Patient Information

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

Supporting Documents/Information (Please provide all of the following)

- Patient insurance information
- Patient medication list
- Supporting clinical notes (H&P) to support primary diagnosis:
  - Indicated diagnosis for IVIG therapy
- Lab documentation of renal status (recent BUN and Serum Creatinine) and/or documentation of any predisposition for renal dysfunction
- Documentation of increased risk of thrombosis. Risk factors may include advanced age, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling vascular catheters, hyperviscosity and cardiovascular risk factors

Orders

NURSING

☑ Nursing care per Harbor Health Nursing Procedures and Harbor Health Adverse Reaction Management Protocol.

☑ **Monitoring: Initial therapy:** check vital signs every 15 minutes for the first 60 minutes, then every 60 minutes for the duration of infusion.
Subsequent therapy (if no previous reaction): check vital signs every 15 minutes for the first 30 minutes, then every 60 minutes for the duration of infusion.

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ¨ 500mg / ¨ 650mg / ¨ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV

☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ Other: _____

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Harbor Health

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Orders, cont.

THERAPY

Harbor Health will select the product based on payor requirements, product availability, and indication: Gamunex-C, Gammagard Liquid, Gammagard SD, HyQvia, Octagam, and Privigen.

Note: Titrate infusion rate as outlined by manufacturer prescribing information.

☐ Round dose to nearest vial size to minimize waste.

☑ Choose an indication below:

☐ **Primary Immunodeficiency (PI)**	_____mg/kg (ref range 100-800mg/kg every 3-4 weeks x_____doses
☐ **Chronic Inflammatory demyelinating polyneuropathy (CIDP)**	***Loading:***_____gm/day **x** _____days; **OR** _____gm/kg/course divided over _____days *(ref range 2g/kg)* ***Maintenance:***_____gm/day **x** _____days; **OR** _____gm/kg/course divided over _____days *(ref range 1g/kg every 3 wks)*
☐ **Multifocal motor neuropathy (MMN)**	_____gm/kg/MONTH (ref range 0.5- 2.4 gram/kg x _____months
☐ **Idiopathic thrombocytopenia purpura (ITP)**	_____gm/day x _____days
☐ **OTHER** (indication _____) **Include dosage, frequency and any other special instructions*	WRITE INSTRUCTIONS HERE

☐ Flush with 5% dextrose in water (D5W) at completion of infusion

☐ Patient is required to stay for 30-minute observation

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ (if not indicated order will expire one year from date signed)

Special Instructions

NOTES:

Provider Name (Print): Provider Signature: Date:

Harbor Health