IV Immune Globulin

(GAMMAGARD LIQUID 10%) – IVIG

6955 Foothill Blvd, Suite 67A, Oakland, CA, 94605
Phone: (510) 878-9528 | Fax: (510) 969-5840 | Email: referrals@totalinfusion.com

Name: ______________________________
DOB: ______________ Phone: ______________
Gender: ☐ Male ☐ Female
Allergies: ______________________________

DIAGNOSIS (ICD-10 code required):

☐ _______ Primary Humoral Immunodeficiency (PI)
☐ _______ Multifocal Motor Neuropathy (MMN)
☐ _______ Other: ____________________

PROVIDER REMINDERS:

- All orders with a ☑ will be placed unless otherwise noted
- Baseline SCr within 3 months of initial treatment

TREATMENT CRITERIA:

Hold IVIG (GAMMAGARD LIQUID) if:

- Temperature **GREATER THAN** 100 degrees F
- Complains of symptoms of acute viral or bacterial illness

Nursing Considerations:

- Monitor for adverse reaction including vital signs and pulse ox, every 30 minutes until max infusion rate achieved, then at the end of infusion, and 30 minutes post infusion

Premedications

☐ **Acetaminophen (TYLENOL) 650mg PO,** Once, 30 minutes prior to IVIG infusion.

☐ **Cetirizine (ZYRTEC) 10mg PO,** Once, 60 minutes prior to IVIG infusion.

☐ ______________________________

☐ **IV LINE CARE** per Nursing Policy

☐ **INFUSION REACTION MEDICATIONS** per Standardized Procedures

☐ **TREATMENT ORDER WEIGHT** will be utilized for the duration of the order. Patient will be weighed prior to every treatment. Prescriber will be notified of weight change greater than 10% from baseline weight.

Medications

Patient Weight _______kg **(REQUIRED)**

Infuse **Intravenous Immune Globulin (GAMMAGARD LIQUID 10%) – IVIG**

Dose:

☐ __________ mg/kg
☐ __________ grams/dose
☐ ____________________

Frequency:

☐ Daily x ______ doses
☐ Every ______ weeks
☐ ______________________________

Administration Rate Table

	First Infusion	Subsequent Infusions
Step 1	0.5ml/kg/hr for 30 minutes	0.5ml/kg/hr for 15 minutes
Step 2	1ml/kg/hr for 30 minutes	1ml/kg/hr for 15 minutes
Step 3	2ml/kg/hr for 30 minutes	2ml/kg/hr for 15 minutes
Step 4	3ml/kg/hr to complete infusion	3ml/kg/hr to complete infusion
Max Rate	Not to exceed 150ml/hr	Not to exceed 300ml/hr

Note: Infusion rate may be decreased based on consideration of age, medical history, risk of renal failure, and patient tolerance.

Special Instruction(s):

Provider Signature ____________________ Date ______________ Email ______________
Printed Name ____________________ Phone ______________ Fax ______________
Office Contact ____________________ Phone ______________ Email ______________