**INTRAVENOUS IMMUNOGLOBULIN (IVIG) ORDERS**
**GENESIS HEALTH SYSTEM**
**[ ] GMC - Davenport, IA [ ] GMC - DeWitt, IA [ ] GMC - Silvis, IL**

**All IVIG orders must be ordered using this order form.**

**Patient Care**

1. Weigh patient in kilograms: _____ kg (Actual Body Weight) Height: _____ inches
2. Monitoring Parameters:
   A. Monitor vital signs pre-infusion, halfway through the infusion, and again upon completion of the infusion
   B. During the infusion, monitor for infusion reactions (facial flushing, chest tightness, chills, fever, dizziness, nausea, vomiting, diaphoresis, hypotension). If an infusion reaction occurs, stop the infusion and contact the provider immediately.
   C. Notify provider immediately of allergic reaction (anaphylaxis, rash, hives), hemolysis, hemolytic anemia, transfusion-related acute lung injury, or thrombotic events
3. Avoid administration of IVIG to patients with Selective IgA Deficiency and antibodies to IgA (in whom anaphylactic reactions can occur)
4. Provider to use caution in patients who have active orders for or who have recently received live attenuated viral vaccines (i.e., Measles/Mumps/Rubella, Rotavirus, Varicella, Herpes Zoster, Live Attenuated Influenza Vaccine - FluMist) because passively transferred antibodies have the potential to inhibit the immune response

**Laboratory**

Baseline BUN and Serum Creatinine unless a Basic Metabolic Profile (BMP) or Complete Metabolic Profile (CMP) was done within 24 hours prior to the initial dose. (Provider to use caution in patients predisposed to acute renal failure as IVIG products have been reported to be associated with renal dysfunction, acute renal failure, osmotic nephrosis and death).

**Medication**

1. Product to be dispensed _____. If not indicated, Pharmacy will dispense hospital preferred IVIG. Genesis Tier 1 Preferred IVIG is Gammagard.
2. **All doses will be based on ideal body weight (IBW) unless actual body weight (ABW) is less than IBW, then ABW will be used**
3. **DOSE: _____ mg IV every _____**
4. Round doses to the nearest 5 gm for all doses greater than 50 gm
   Round doses to the nearest 1 gm for all doses less than 50 gm
5. Indication/Recommended Dosing (Provider to order specific dose on line #5):
   [ ] B-CELL CHRONIC LYMPHOCYTIC LEUKEMIA (CLL), SECONDARY IMMUNODEFICIENCY OR RECURRENT BACTERIAL INFECTIONS
   (Recommended Dose: 400 mg/kg IV every 3 to 4 weeks)
   [ ] BONE MARROW TRANSPLANTATION (Adjunct)
   (Recommended Dose: 500 mg/kg IV on days 7 and 2 pre-transplant then weekly through day 90 post-transplant)
   [ ] CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIC PURPURA (ITP)
   (Recommended Dose: 1 gm/kg IV once daily X 2 consecutive days)
   [ ] CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP)
   (Recommended Loading Dose: 2 gm/kg IV given in divided doses over 2 to 4 days
   Recommended Maintenance Dose: 1 gm/kg IV every 3 weeks)
   [ ] GUILLAIN-BARRE SYNDROME
   (Recommended Dose: 400 mg/kg IV once daily X 5 days)
   [ ] KAWASAKI SYNDROME
   (Recommended Dose: 2 gm/kg IV X 1 dose within 10 days of disease onset)
   [ ] MULTIFOCAL MOTOR NEUROPATHY
   (Recommended Initial Dose: 2 gm/kg IV given in divided doses over 2 to 5 days
   Recommended Maintenance Dose: 1 gm/kg IV every 2 to 4 weeks or 2 gm/kg IV every 1 to 2 months)
   [ ] MULTIPLE SCLEROSIS (Relapsing-Remitting)
   (Recommended Dose: 1 gm/kg IV once monthly)
   [ ] MYASTHENIA GRAVIS (Severe Exacerbation)
   (Recommended Dose: 400 mg/kg IV once daily X 5 days)
   [ ] PRIMARY IMMUNODEFICIENCY (Common Variable Immunodeficiency, Congenital Agammaglobulinemia, Severe Combined Immunodeficiencies, Wiskott-Aldrich Syndrome, X-linked Agammaglobulinemia)
   (Recommended Dose: 200 to 800 mg/kg IV every 3 to 4 weeks)

   [ ] OTHER Indication and Dose: _____
   **(Per P&T Committee, use for indications other than those listed above requires prior Medical Staff approval before IVIG may be dispensed and administered. Notify P&T Committee Chair for approval).**

_____
Signature of Physician

_____ _____
Date Time