

ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800
Please mark the appropriate infusion center:

- Allenmore Infusion Center
- Auburn Infusion Center
- Gig Harbor Infusion Services
- Puyallup Infusion Center
- DHEC Infusion Center
- North Spokane Infusion Center
- North Star Lodge Infusion Center

ORDERS WITH CHECK BOXES

When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Immune Globulin (IVIG)

Patient Name: _____ Requested Date of Service: ____/____/____

Date of Birth: ____/____/____ Patient Phone Number: (____) _____ - _____ May leave message

- Diagnosis:**
- CIDP (chronic inflammatory demyelinating polyneuropathy)
 - ITP (immune thrombocytopenia)
 - Guillain-Barre (failed plasmapheresis)
 - Hypogammaglobulinemia
 - Other _____

ICD -10 Code:

- _____
- _____
- _____
- _____
- _____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs

If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

Baseline Labs Required:

- CBC/CMP

Maintenance Labs Required:

- CBC/CMP every 6 months

IV Access: Access and/or maintain IV site in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal.

Patient actual weight = _____ lb/kg (required) Date weight taken: _____
For dosing weight, pharmacy will use IBW; for patients who are >30% of IBW, pharmacist will calculate dose based on an adjusted body weight
Dosing weight (kg) = _____ IBW/Adj BW

Treatment Regimen:

- Pre-meds given 30 minutes prior to infusion:**
 - Acetaminophen 650 mg po x 1 dose
 - Diphenhydramine 25 mg po x 1 dose or loratadine 10 mg po x 1 dose if intolerant to diphenhydramine

Immune Globulin (IVIG) Dose: Rounded to nearest 5 gm, infused per MHS IVIG guidelines

Dose: _____ gm/kg = _____ gm for 1 dose or _____

Vital Signs: Check vital signs per MHS IVIG guideline.

Contact provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4F)

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for further orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: Yes No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature _____

Print Name _____

Date _____

Time _____

Another brand of drug, identical in form and content, may be dispensed unless checked

Orders expire in 12 months**

Patient Identification - Always Attach Patient Label

Name: _____

MRN #: _____

CSN #: _____

Age / Sex and Gender: _____

Pre-printed Order
IMMUNE GLOBULIN (IVIG)



78-0026-8MR (Rev. 9/24)