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:		**ICD -10 Code:**
	❑ CIDP (chronic inflammatory demyelinating polyneuropathy)	❑ _____
	❑ ITP (immune thrombocytopenia)	❑ _____
	❑ Guillain-Barre (failed plasmapheresis)	❑ _____
	❑ Hypogammaglobulinemia	❑ _____
	❑ Other_____	❑ _____

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 futher 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)

MultiCare

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