NORMAN REGIONAL Health System

Outpatient Infusion Center

Fax: 405-515-5089
Phone: 405-515-2470

ORD

Immunoglobin Intravenous (IVIG)

Patient and Physician Information

Patient Name:	Date of Birth:	Patient Phone Number:
Physician Name:	**Office Phone Number:**	**Fax Number:**
Insurance:	**Group Number:**	**Policy Number:**
Hospitalization Status:	**Patient Weight (kg):**	**Height (inches):**
☑ Outpatient to Outpatient Infusion Center		
Allergies:		

*****Send patient demographics/insurance, clinical notes, and test results with orders*****

Diagnosis Code/Description for treatment: _____

☐ Chronic Inflammatory Demyelinating Polyneuritis (G61.81)
☐ Nonfamillial Hypogammaglobinemia (D80.1) - Document IgG Level_____mg/dL from what date: _____
Document infection history (current/recurrent infection):_____
☐ Immune Thrombocytopenic purpura (D69.3)
☐ Other Primary Thrombocytopenia (D69.49)

Orders

Initiate IV Vascular Access Flush Orders #0643 for: ☐ Peripheral Line ☐ Midline ☐ PICC ☐ Port

☑ Baseline vital signs then every 15 minutes x 4, then every 2 hours until infusion completed. If rate reduction is required, resume every 15 minute vital signs until symptoms resolved and vital signs returned to previous x 2.
☑ Notify physician of: *Heart rate 20% GREATER THAN baseline *Respiratory distress or rate 20% GREATER THAN baseline *Temperature GREATER THAN 38.5 degrees Celsius * Systolic blood pressure 20% LESS THAN baseline * Hives
☑ Discontinue infusion and notify physician, if patient has: systolic blood pressure LESS THAN _____ mmHg

☑ Normal Saline 0.9% Solution 20 milliliter/hour INTRAVENOUS (J7050 : 250 ML = 1 unit)

Premedication

☐ DiphenhydrAMINE (Benadryl) 25 MG ORAL ONCE 30 minutes prior to IVIG infusion (J1200 : 50 MG = 1 unit)
☐ Acetaminophen (Tylenol) 325MG 2 TAB ORAL ONCE 30 minutes prior to IVIG infusion
☐ methylPREDNISolone (Solu-Medrol) 125 MG IV PUSH ONCE 30 minutes prior to IVIG infusion. (J2930 : 125 MG = 1 unit)

Infusion – Verify Insurance coverage to determine best product

☐ Privigen (J1459 : 500 MG = 1 unit) ☐ Octagam ((J1568 : 500 MG = 1 unit) ☐ Gammagard (J1569 : 500 MG = 1 unit)

☑ Immune Globin (IgG) 10% _____ mg/kg (Patient's Ideal Body Weight) [TOTAL DOSE:____ MG] at 30 milliliter/hour –Increase rate gradually by 30 mL/hr, allowing 15 to 30 minutes before each incremental increase. ** DO NOT EXCEED 150 mL/hr. If patient experiences flank pain, fever, tachycardia, bradycardia – REDUCE rate to the previous increment. (Dose will be rounded to the nearest vial size based on patient's current weight.)

Infusion Reaction

☑ If infusion reaction occurs, stop the infusion IMMEDIATELY, notify physician with details of reaction AND initiate the Outpatient Infusion HYPERsensitivity, OIC orders #1024

Discharge

☑ Discharge home 30 minutes after treatment complete if stable.

Date and Physician Signature

DATE:_____ **TIME:**_____

_____
PHYSICIAN'S SIGNATURE

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DO NOT WRITE ON OR BELOW THIS AREA ORDERS MAY BE CUT OFF BY FAX MACHINES