INTRAVENOUS IMMUNOGLOBULIN (IVIG) ORDERS:

Name: ________________________________ **DOB:** ______________ **Height:** _____ **Weight:** _____ **(kg)**

Allergies/Reactions: ____

1. Premedication:
   - _____Aspirin 325 mg (unless patient has ITP) x 1 dose
   - _____diphenhydrAMINE 25 mg IV x 1 dose
   - _____Acetaminophen 650 mg PO x 1 dose
   - _____MethylPREDNISonlone 125 mg IV x 1 dose
   - _____Other:____

2. Labs: ____

3. Indication for IVIG Therapy – Check appropriate:
   - _____Primary Immunodeficiency: (Recommended dose= 400-600 mg/kg every 3-4 weeks)
     - Current serum IgG level: ____________ Date:_________________
   - _____Idiopathic Thrombocytopenic Purpura (ITP): (Recommended dose= 400 mg/kg/day x 5 days or 1 gm/kg x 1-2 days)
     - Active Bleeding __________Yes _________ No
     - Current Platelet count:________________ Date:___________________
   - _____B Cell Chronic Lymphocytic Leukemia (CLL):
     (Recommended dose= 200-400 mg/kg every 3-4 weeks)
     - Current serum IgG level:____________ Date:________________
   - _____Kawasaki Syndrome: (Recommended dose= 2 gm/kg/dose x 1)
   - _____Chronic Inflammatory Demyelinating Polyneuropathy (CIDP):
     (Recommended INITIAL dose= 2 gm/kg IV over 2-5 days: ie: 400 mg/kg/day x 5 days or 1 gm/kg/day x 2 days. MAINTENANCE dose: 400 mg-1 gm/kg over 1-2 days every 2-6 weeks)
     - Acute Exacerbation _________Yes_________No
   - _____Myasthenia Gravis:
     (Recommended dose= 2 gm/kg over 2-5 days, ie: 400 mg/kg/day x 5 days)
     - Acute Exacerbation_________Yes _____________No
   - _____Guillain-Barre Syndrome: (Recommended dose= 400 mg/kg/day x 5 days -adults and pediatrics or 1 gm/kg/day x 2 days – pediatrics only)
   - _____Other: ____

4. Dosage (see above for recommended dosages):
   - Infuse IVIG 10 % ____________ mg/kg IV x _______ days
   - Choose one of the following:
     - _____No repeat dose
     - _____Repeat dosage every _______ weeks
   - Round dose to nearest vial size to minimize waste
   - Administer per MD order or refer to package insert for infusion instructions

5. Monitor for signs and symptoms of allergic reaction. Notify MD if signs and symptoms of allergic reaction

6. IV Line Care:
   - Normal Saline 10 ml IV flush after each use
   - For implanted ports: Heparin 100 units/ml 5 ml IV flush after each use or prior to deaccessing

7. Discharge when infusion complete

8. Other Orders:____

New MD order required every 6 months unless defined in original order

Physician Signature:____________________________Date/Time:____________

Patient Name: «Full_Name»; DOB: «Birth_Date»
Physician Name: «Attending_Physician_Last_Name», «Attending_Physician_First_Name»
Visit ID: «Visit_ID»