



Lansing, Michigan

IVIG Orders - Infusion Center

Name _____

Date _____ Time _____

Weight _____ Height _____

Call to schedule appointment (517) 364-5510 fax #: (517) 364-5511.

FDA Approved Indication for IVIG	Recommended Doses
<p>Please check the indication which applies to the patient.</p> <p><input type="checkbox"/> Replacement therapy in primary immune deficiency syndrome _____ IgG level 5-6g/L OR _____ IgG level greater than 6g/L & infectious symptoms IgG level _____ date _____</p>	<p>0.2 Gm/kg every 3-4 weeks. Dose adjusted to maintain trough immune globulin G levels of 5 Gm/L and/or reduction in the incidence of infection</p>
<p><input type="checkbox"/> Idiopathic thrombocytopenic purpura (Consider use of WinRho) _____ Platelets 30,000-50,000 & severe bleeding OR _____ Platelets less than 30,000 Platelet count _____ date _____</p>	<p>Dosage (check one) _____ Acute ITP: 0.8 Gm/kg times 1 _____ Chronic ITP: 0.4 Gm/kg every 3-4 wks.</p>
<p><input type="checkbox"/> Prophylaxis of infection and treatment of hypogammaglobulinemia in B-cell CLL</p>	<p>0.4 Gm/kg/dose every 3-4 weeks</p>
<p><input type="checkbox"/> Kawasaki Disease (administer within 10 days of onset of illness and before aneurysms occur)</p>	<p>2 Gm/kg as a single dose</p>
<p><input type="checkbox"/> Prophylaxis against infections and/or graft-versus host disease after bone marrow transplantation</p>	<p>0.5 Gm/kg on days 7 & 2 before transplant, then every week until 90 days post transplant</p>
<p><input type="checkbox"/> Prophylaxis against bacterial infections in children with AIDS</p>	<p>0.4 Gm/kg every 28 days</p>

Initiate Anaphylaxis Protocol if needed: _____

Labs: _____

Premeds: _____

acetaminophen (Tylenol®) _____mg (PO)

antihistamine: _____ mg (IV / PO)

use central venous access device or start peripheral venous access

Heparin for central venous access device flush:

I/P 500 units/ml PICC/tunnelled catheter 250 units/ml Peripheral 100 units/ml

Discontinue peripheral device after infusion is complete.

Diet: _____ Activity: _____

Discharge home when vital signs stable.

Follow-up appointment: Date _____ Time: _____

Pharmacy Use Only: _____ **Pharmacists Initials:** _____

1. Patient Weight _____kg (ABW) _____kg (IBW) (Use ABW if under 16 years old, IBW if 16 years and older)

2. Dosage calculation: _____ Gm/kg times _____ kg = _____

3. Round dose down to nearest vial = _____

Authorization is granted to supply by non-proprietary name as per formulary policy unless checked here.

<p>Doctor X</p>	<p>Reg. No.</p>	
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<p>Verbal/Telephone orders read back <input type="checkbox"/> yes</p>	<p>Date</p>	<p>Time</p>
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<p>Noted By X _____ R.N.</p>	<p>Date</p>	<p>Time</p>
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