

AIS INTRAVENOUS IMMUNE GLOBULIN (IVIG) ORDERS

Patient Name: _____ DOB: _____

Ordering Provider: _____

Weight _____ kg _____ lbs (actual body weight)

Diagnosis: _____ ICD-10 Code: _____

1. Is this the first dose of IVIG for this patient? Yes No

Give one hour prior to start of Intravenous Immune Globulin infusion:

- Acetaminophen 650mg orally times 1 dose Diphenhydramine 25mg orally times 1 dose
 Other: _____

IVIG administration:

1. A. IVIG _____ gm/kg (final dose to be determined by pharmacy)

Dosing weight: _____ kg (use IBW for all patients except patients weighing >30% of IBW)
If patient weighs > 30% IBW use adjusted body weight = IBW + 0.4 (TBW-IBW)
Calculated IVIG dose: _____ gm
RPH: _____

B. IVIG _____ gm/kg (total dose)

C. Frequency: Daily for _____ days weekly for _____ weeks monthly for _____ months

D. Other: _____

2. Infuse IVIG over a period of NOT LESS than 2 hours. DO NOT administer as IV push or bolus.

3. When the infusion is complete, flush the line with Normal Saline 20mL to clear line of all active drug.

4. Do not infuse other medications into the IV line with IVIG.

Labs:

- CBC, SCr, HTC, HGb, prior to initial infusion prior to each infusion Other: _____
Call prescriber if SCr > 1.5 or BUN > 50% baseline
 Other: _____

Vital Signs:

1. Take prior to infusion and every 30 minutes x2 then hourly during infusion and after each rate change.
2. Call physician if: systolic BP less than _____ mmHg or blood pressure greater than _____ mmHg,
temperature greater than _____ °F

For moderate to severe infusion reaction:

1. Stop infusion and call rapid response immediately.
2. Oxygen by nasal cannula at 2 Liters per minute as needed for dyspnea.
3. Diphenhydramine 50mg IV push over 3 minutes.
4. Hydrocortisone sodium succinate 100mg IV push as needed for anaphylaxis
5. Notify ordering physician after patient stabilized. Hold all future doses.

Other: _____

Ordering Providers Printed Name _____

Ordering Providers Signature _____ Date _____ Time _____

Cosigning Providers Signature (if required) _____ Date _____ Time _____



M.IVIGO

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