Immune Globulin (Gammagard Liquid) - IVIG
Infusion Therapy Plan Orders

Instructions to Provider
Review orders and note any changes. All orders with ☑ will be placed unless otherwise noted. Please fax completed order form to the infusion center where the patient will be receiving treatment (see fax numbers page 2).
Lab orders are not included on this form – place orders via usual method. Lab monitoring is the responsibility of the ordering physician.

Please complete all of the following:

☐ Pre-Service Authorization has been obtained by Kaiser Permanente Fax: 1-888-282-2685  Voice: 1-800-289-1363

<table>
<thead>
<tr>
<th>Order Date: _____________</th>
<th>Diagnosis:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight: _______kg</td>
<td>ICD-10 code (REQUIRED): ________________</td>
</tr>
<tr>
<td></td>
<td>ICD-10 description ____________________________________________</td>
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</tbody>
</table>

General Plan Communication
- Special instructions/notes: ____________________________________________

Provider Information
- Infusion rates should not go beyond 3.2 mg/kg/min for
  - Patients at risk for thrombotic event or
  - Patients with risk factors for renal dysfunction (over 65 years old, diabetes, abnormal renal function tests)

Infusion Therapy

☑ Immune globulin-human (GAMMAGARD LIQUID) 10% IV infusion
  **Dose:** _______ grams/dose (will be rounded the nearest 1 gm)
  **Route:** Intravenous
  **Frequency:**
  - ☐ daily x 2 doses _______
  - ☐ every _____ weeks x 6 months
  - ☐ daily x 4 doses _______
  - ☐ ________________

  **Infusion Rate:** Titrate per Kaiser Permanente Nursing Protocol – IV Immune Globulin

  **Note any changes to above regimen:** ________________________________

Pre-Meds

☑ acetaminophen (TYLENOL) tablet
  **Dose:** 650 mg  **Route:** Oral  **Frequency:** Once, 30 minutes prior to IVIG infusion.
  May also be given once as needed during infusion for fever, headache or myalgia to infusion.

☑ cetirizine (ZYRTEC) tablet
  **Dose:** 10 mg  **Route:** Oral
  **Frequency:** Once, at least 60 minutes prior to IVIG infusion (if not taken at home).

☐ Other: _______  **Dose:** _______  **Route:** Oral  **Frequency:** Once, 30 minutes prior to IVIG infusion

☐ No routine pre-medications necessary. Above pre-meds may be given if patient has reaction and requires pre-medications for future doses.

Provider Signature: ____________________________________________   Date: _______________
Printed Name: ______________________________________  Phone: ___________ Fax: ___________
IV Line Care
- dextrose 5% infusion (D5W) 250 mL
  Rate: 30 mL/hr  Route: Intravenous  Frequency: Run continuously to keep vein open
  Start peripheral IV if no central line
- heparin flush 100 unit/mL
  Dose: 500 units  Route: Intracatheter  Frequency: PRN for IV line care per Nursing Policy

Infusion Reaction Meds
- albuterol (PROVENTIL) nebulizer solution 0.083%
  Dose: 2.5 mg  Route: Nebulization  Frequency: PRN for shortness of breath/wheezing
- diphenhydrAMINE (BENADRYL) injectable
  Dose: 25 mg  Route: Intravenous
  Frequency: Once PRN, May repeat x1 for urticaria, pruritis, shortness of breath. May repeat in 15 minutes if symptoms not resolved.
- EPINEPHrine 1 mg/mL (1:1000) injectable
  Dose: 0.3 mg  Route: Intramuscular
  Frequency: Once PRN for anaphylaxis. Notify physician if administered.
- hydrocortisone sodium succinate (SOLU-CORTEF) injectable
  Dose: 100 mg  Route: Intravenous  Frequency: Once PRN for hypersensitivity

Lab Review for Nursing
- Ensure baseline lab (e.g. Scr) is drawn within 3 months of initial treatment if providers have ordered.

Nursing Orders
- Weight should be recorded at least every 6 months or more frequently as appropriate. Notify physician if weight has changed 10% or greater from baseline.
- If infusion-related reaction, 1) STOP infusion immediately; 2) Increase primary infusion to wide open rate; 3) Administer PRN medications per hypersensitivity protocol; 4) Notify MD
- Stop infusion and report these signs of adverse effects to provider and/or call the code team immediately: 1) Transfusion-related acute lung injury (TRALI): severe respiratory distress, pulmonary edema, hypoxemia, fever in the presence of normal left ventricular function, sudden development of dyspnea, and hypotension
- Discontinue IV line when therapy complete and patient stabilized.

References
- GAMMAGARD Prescribing Information Revised June 2012.
- Kaiser Permanente Nursing Protocol - IV Immune Globulin (for internal use only)

Kaiser Permanente Infusion Locations

Bellevue Medical Center
11511 NE 10th St, Bellevue, WA 98004
Fax: 425-502-3512  Phone: 425-502-3510

Capitol Hill Medical Center
201 16th Ave E, Seattle WA 98112
Fax: 206-326-2104  Phone: 206-326-3109

Everett Medical Center
2930 Maple St, Everett, WA 98201
Fax: 425-261-1659  Phone: 425-261-1681

Olympia Medical Center
700 Lily Road N.E., Olympia, WA 98506
Fax: 360-923-7106  Phone: 360-923-7164

Riverfront Medical Center – Spokane
W 322 North River Drive, Spokane, WA 99201
Fax: 509-324-7168  Phone: 509-241-2073

Silverdale Medical Center
10452 Silverdale Way NW, Silverdale, WA 98383
Fax: 360-307-7493  Phone: 360-307-7444

Tacoma Medical Center
209 Martin Luther King Jr Way, Tacoma, WA 98405
Fax: 253-383-6262  Phone: 253-596-3666

Provider Signature: ____________________________________________   Date: _______________
Printed Name: ______________________________________  Phone: ___________ Fax: ___________