**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>
</tr>
</tbody>
</table>

**General Plan Communication**

- Special instructions/notes: __________________________________________________

**Provider Information**

- Infusion rates should not go beyond 4 mg/kg/min for
- Patients with ITP diagnosis or
- 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**

*NOTE:* IVIG GAMMAGARD LIQUID is the standard product used at Kaiser Permanente Facilities (as of Oct 2014). Please use the order form for IVIG GAMMAGARD LIQUID unless an exception for Privigen is on file.

- ☑️ Immune globulin-human (PRIVIGEN) 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:* Titrated 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.
- ☑️ 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: _____________

Revision Date: 2/6/2017 Kaiser Permanente  <Reference#115107>
IV Line Care
- 0.9% sodium chloride infusion 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
- PRIVIGEN® Prescribing Information. Revised September 2012.
- Nursing Protocol - IV Immune Globulin (for internal use only)

Kaiser Permanente Infusion Locations

<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bellevue Medical Center</td>
<td>11511 NE 10th St, Bellevue, WA 98004</td>
<td>425-502-3512</td>
<td>425-502-3510</td>
</tr>
<tr>
<td>Capitol Hill Medical Center</td>
<td>201 16th Ave E, Seattle WA 98112</td>
<td>206-326-2104</td>
<td>206-326-3109</td>
</tr>
<tr>
<td>Everett Medical Center</td>
<td>2930 Maple St, Everett, WA 98201</td>
<td>425-261-1659</td>
<td>425-261-1681</td>
</tr>
<tr>
<td>Olympia Medical Center</td>
<td>700 Lily Road N.E., Olympia, WA 98506</td>
<td>360-923-7106</td>
<td>360-923-7164</td>
</tr>
<tr>
<td>Riverfront Medical Center – Spokane</td>
<td>W 322 North River Drive, Spokane, WA 99201</td>
<td>509-324-7168</td>
<td>509-241-2073</td>
</tr>
<tr>
<td>Silverdale Medical Center</td>
<td>10452 Silverdale Way NW, Silverdale, WA 98383</td>
<td>360-307-7493</td>
<td>360-307-7444</td>
</tr>
<tr>
<td>Tacoma Medical Center</td>
<td>209 Martin Luther King Jr Way, Tacoma, WA 98405</td>
<td>253-383-6262</td>
<td>253-596-3666</td>
</tr>
</tbody>
</table>

Provider Signature: ________________________________ Date: ________________
Printed Name: ________________________________ Phone: ________________ Fax: ________________