




<p style="text-align: center;">THE UNIVERSITY OF KANSAS HOSPITAL KUMED 3901 Rainbow Boulevard Kansas City, Kansas 66160</p>	<p>Do not write in this box</p>  DT0017	<p>PATIENT LABEL</p>
PHYSICIAN'S ORDER FORM		

DATE & TIME	#	ORDERS INTRAVENOUS IMMUNE GLOBULIN (IVIG)
		Reference: Murphy, E., Martin, S., Patterson, J. V. Developing Practice Guidelines for the Administration of Intravenous Immunoglobulin. Journal of Infusion Nursing. 2005;28(4): 265-272.
	1.	<i>Order Initiation Date:</i> _____ <i>(Expires 6 months from initiation date)</i>
	2.	Allergies: _____ Patient Weight: _____ kg
	3.	Attending Physician: _____ Pager # _____ Resident Physician: _____ Pager # _____
	4.	Diagnosis: ICD 9 Code: <input type="checkbox"/> 204.10 Lymphoid leukemia, chronic, without mention of remission <input type="checkbox"/> 279.00 Hypogammaglobulinemia <input type="checkbox"/> 279.06 Common variable immunodeficiency <input type="checkbox"/> 357.81 Chronic inflammatory demyelinating polyneuritis <input type="checkbox"/> 710.0 Systemic lupus erythematosus <input type="checkbox"/> 710.3 Dermatomyositis <input type="checkbox"/> V42.0 Kidney replaced by transplant <input type="checkbox"/> V42.1 Heart replaced by transplant <input type="checkbox"/> V42.6 Lung replaced by transplant <input type="checkbox"/> V42.7 Liver replaced by transplant <input type="checkbox"/> Other: _____
	5.	Indications: _____
	6.	Nursing: <ul style="list-style-type: none"> • Obtain patient weight with each infusion. • Obtain vital signs (temperature, heart rate, blood pressure and respiratory rate) prior to the start of the infusion, every 15 minutes X 1 hr, every hour, and at completion of the infusion. • Insert 22 gauge or 24 gauge IV and saline lock. • <u>If a reaction occurs</u>, decrease infusion rate by 30 mL every 15 minutes along with monitoring vital signs, until symptoms subside. After symptoms subside, wait 30 minutes before re-initiating infusion. If reaction persists, stop infusion and notify physician.
	7.	Labs to be drawn prior to infusion: _____
	8.	IV Fluids: <ul style="list-style-type: none"> • Use D5W to prime IV tubing and to flush before/after infusion. • Flush IV site with 20 mL D5W at the completion of the infusion.
	9.	Pre-medication orders: <input type="checkbox"/> Dexamethasone (Decadron) _____ mg IV 30 minutes prior to infusion. <input type="checkbox"/> Acetaminophen (Tylenol) 500 mg po 30 minutes prior to infusion. <input type="checkbox"/> Loratadine (Claritin) 10 mg po 30 minutes prior to infusion. <input type="checkbox"/> Ibuprofen _____ mg po 30 minutes prior to infusion. <input type="checkbox"/> Diphenhydramine (Benadryl) 25 mg IV 30 minutes prior to the infusion.

INTRAVENOUS IMMUNE GLOBULIN (IVIG)



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	10.	<p>Medications:</p> <p><input type="checkbox"/> Intravenous Immune Globulin (IVIG) _____ gm (0.4-2 gm/kg/dose) IV q _____ X 6 months.</p> <p><input type="checkbox"/> In the event of patient intolerance to particular IVIG brands, please specify desired brand: _____</p> <ul style="list-style-type: none"> • DO NOT infuse any other medication concurrently through the same IV access. <p>IVIG:</p> <ul style="list-style-type: none"> • If using any IVIG other than Gamunex™, initiate infusion at 30 mL/hr X 15 min. INCREASE rate by 30 mL/hr every 15 minutes not to exceed 240 mL/hr. • See Intravenous Immune Globulin Nursing Standard of Practice for infusion rate guidelines and monitoring. <p>GAMUNEX™:</p> <ul style="list-style-type: none"> • If Gamunex™ is indicated, initiate infusion at 15mL/hr X 15 min. INCREASE rate by 15 mL/hr every 15 minutes not to exceed 120 mL/hr.
	11.	<p>Call Physician _____ Pager _____</p> <p>IF:</p> <ul style="list-style-type: none"> • Temperature >38.5 C • Pulse <60 or >120 BPM • Respirations <12 or >35 breaths per minute • SaO₂ <92% or increased O₂ needs • SBP <90 or >160; DPB <50 or >100; MAP of 60 • FSBS <60 or >300 mg/dL <p>SLOW Infusion and Notify the physician immediately for any new onset of the following: flushing, fever, nausea, diaphoresis, hypotension, urticaria, chills, dizziness, headache, body aches, back ache, vomiting, myalgia, chest tightness, tachycardia or shortness of breath.</p> <p>STOP the infusion immediately, administer reaction management medications, call rapid response/code team as appropriate, and page the physician for any new onset of the following life threatening hypersensitivity reactions including: anaphylaxis, acute renal insufficiency, thrombotic events or aseptic meningitis</p>
	12.	<p>Reaction Management:</p> <ul style="list-style-type: none"> • Methylprednisolone (Solumedrol) 125mg IV x1 prn for urticaria, pruritus • Acetaminophen (Tylenol) 500 mg po q 4 hours prn myalgias or fever > 38.5 C. • Diphenhydramine (Benadryl) 25 mg IV q 4 hours prn urticaria, pruritus, or shortness of breath. • Oxygen by nasal cannula 2 L/minute prn chest pain or dyspnea. • If symptoms are <u>rapidly progressing or continue</u> after the diphenhydramine, give epinephrine (1:1000 strength) 0.3 mL subcutaneously. May repeat every 10-15 minutes to maximum of 6 doses.
	13.	<p>DC IV and discharge to home.</p>

Physician Signature: _____ Pager: _____ Date: _____ Time: _____