# Intravenous Immune Globulin (IVIG)

REDINGTON-FAIRVIEW GENERAL HOSPITAL
(207) 474-5121 / WWW.RFGH.NET
Skowhegan, Maine 04976

Patient Weight: _____kg Height: _____inches

**DIAGNOSIS:** [ ] Myasthenia Gravis [ ] Chronic inflammatory demyelinating polyneuropathy
[ ] Immune thrombocytopenia [ ] Other:

**PRE-MEDICATE:** (30 minutes before infusion)

[ ] Acetaminophen PO 650 mg **-or-** _____ mg
[ ] Famotidine 40 mg PO **-or-** [ ] Pantoprazole 40mg PO
[ ] Loratadine 10mg PO **-or-** [ ] Diphenhydramine PO 25 mg **- or-** _____ mg
[ ] MethylprednisoLONE IV 40 mg IV – or- _____ mg **- or-** [ ] Hydrocortisone IV 100mg
[ ] Ibuprofen PO 400 mg **– or-** _____ mg
[ ] Other:

**Immune Globulin 10 %** [ ] Privigen (preferred) [ ] Gammunex-C [ ] Other_____

[ ] 0.4 g/kg IV [ ] Daily x _____Days
[ ] 0.5 g/kg IV [ ] Daily x _____Days then every _____ Weeks*
[ ] 0.6 g/kg IV [ ] Every _____Weeks*
[ ] Other:_____ g/kg IV *Duration: _____ (max. 12 months)

**Dosing Weight:** Doses will be rounded to nearest 5 grams

[ ] Ideal body weight (default)
[ ] Adjusted body weight –BMI > 30
[ ] Total requested dose:_____ grams
(optional. Pharmacy will calculate based on above)

**NURSING:**

- Instruct patient of signs of infusion type reaction and to immediately report headache, difficulty breathing, chest pain or any discomfort.
- Vital signs and titration per crease in rate RFGH policy "IMMUNE GLOBULIN INFUSION PROCEDURE" Call provider if blood pressure > 160/90, or temperature > 101ºF
- **Other:**

**Checklist for non-RFGH credentialed providers:**

[ ] Problem list, current medication and allergies attached
[ ] Provider to provider communication is required. If the patient has a Primary Care Provider at RFGH, please contact that PCP. Otherwise, call (207) 474-5121 and ask to speak to hospitalist .

Contacted provider: _____

**REQUIRED Prior Authorization Number:** _____ [ ] pending [ ] Complete [ ] not needed*
*If not needed is chosen, date, time and name of person at health insurer who authorized.

Date:_____ Time:_____ Duration of authorization:_____

**FAX to RFGH Infusion clinic at 207-858-2404** **Contact Infusion Clinic at 207-858-8722**

Revised 7/8/25

Provider signature _____Date_____time_____

*If not RFGH credentialed*: Printed name_____ Phone # _____

**RFGH Co-signature** _____

Date_____ time:_____

Patient _____

dob_____ phone #_____