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:**

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:_____

Checklist for non-RFGH credentialed providers:
[ ] Problem list
[ ] Current medication and allergy list

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

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Provider signature _____Date_____time_____

Printed name_____ Phone # _____

Label or
Patient name_____

Date of birth_____ Patient phone number_____