Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_ Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD-10 Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ordering Physician Name (*please print*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pre-Medications to be given 30 minutes prior to start of infusion:**

Acetaminophen 650mg PO  Methylprednisolone 40 mg IV push  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Select ONE only:**

Diphenhydramine 25 mg PO  Diphenhydramine 50 mg PO

Diphenhydramine 25 mg IV push  Diphenhydramine 50 mg IV push

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immune Globulin Intravenous (IVIG): *All orders will be filled using Gammagard 10%, unless Gammagard S/D is medically necessary***

Gammagard 10% Immune Globulin Intravenous

Gammagard S/D 5% Immune Globulin Intravenous (brand medically necessary)

Weight based dose: \_\_\_\_\_\_\_\_\_\_ mg/kg calculated \_\_\_\_\_\_\_\_\_\_\_ grams (rounded to nearest 5 grams)

OR

Fixed dose: \_\_\_\_\_\_\_\_\_\_\_\_ grams (rounded to nearest 5 grams)

**Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Assess for signs/symptoms of hypersensitivity &/or anaphylaxis:**

If signs/symptoms of reaction, administer Diphenhydramine 25 mg IV push (may repeat x1 in 15 minutes) AND Methylprednisolone 40 mg IV push

Ondansetron 4 mg IV push x1 for nausea

**Also required from physician office:**

* History and Physical or Assessment and Plan or Physician Office Progress Note
* Insurance authorization

**Authorization # and Dates** (from and to):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Office Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Rate of Administration1 :**

For all formulations, infusing too rapidly may cause a precipitous hypotensive reaction. Decrease rate of infusion at onset of patient discomfort or any adverse reactions. Decrease rate in patients at risk for neuromuscular disorders. IVIG products have been associated with renal dysfunction, acute renal failure, osmotic nephrosis, and death. For patients with any degree of renal insufficiency, age 65 years and older, with diabetes mellitus, paraproteinemia, sepsis, volume deletion, or known to be receiving nephrotoxic drugs: administer at the minimum rate of infusion practicable.

**Gammagard 10% and Gammagard S/D 5% Immune Globulin**

Initial Infusion Rate: 0.5 mL/kg/hour for the first 30 minutes,

If tolerated, infusion rate can be titrate as follows:

1 mL/kg for 30 minutes, then

1.5 mL/kg for 30 minutes, then

2 mL/kg for 30 minutes

**Maximum infusion rate:**

|  |  |  |  |
| --- | --- | --- | --- |
| Drug/Indication | Primary Immunodeficiency (PI) | Multifocal Motor Neuropathy | Unspecified |
| Gammagard 10% | 5 mL/kg/hr | 5.4 mL/kg/hr |  |
| Gammagard S/D 5% |  |  | 4 mL/kg/hr |

1. Collins, S.R. Intravenous Medications: A Handbook for Nurses and Health Professionals 38th ed. St. Louis, MO; Elsevier; 2022