Oregon Health & Science University Hospital and Clinics Provider's Orders PO9031 ADULT AMBULATORY INFUSION ORDER **Immune Globulin (IVIG) Infusion** Page 1 of 4	ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE *Patient Identification*

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. Pharmacist to round dose to nearest whole vials. Pharmacist to order appropriate combination of vial sizes to administer total ordered dose. For doses that require more than one vial, orders should be prescribed as "once" order(s). For multiple consecutive days: Round dose to administer same dose each day, and set interval to "every visit" (for example, for dose of 70 grams over 2 days, order as 35 grams with "every visit" interval).
3. In patients who may be at risk of renal failure, a decrease in dose, rate, and/or concentration should be considered. IVIG should be given at a rate of less than 2 ml/kg/hr for the 10% solution. Avoid use in patients with CrCl less than 10 ml/min.
4. Adjusted Body Weight will be used when a patient has an Actual Body Weight (ABW) greater than 130% of Ideal Body Weight (IBW). Otherwise, IBW or ABW will be used, whichever is lowest.
    a. IBW Males (kg) = 50 + (2.3 x (height in inches – 60))
    b. IBW Females (kg) = 45.5 + (2.3 x (height in inches – 60))
    c. If height < 60 inches, use 50 kg (male) and 45.5 kg (female) to calculate IBW
    d. Adjusted Body Weight= IBW + 0.4 (Actual Body Weight – IBW)
5. Traditional Medicare: Hizentra SUBQ formulation is indicated for Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) and Primary Immunodeficiency (PI). Off-label indications may result in extended prior authorization processing.
6. Patients being considered for transition to SUBQ IVIG should have received intravenous IVIG infusions routinely for at least 3 months before switching to SUBQ.
7. Subcutaneous formulation Hizentra is contraindicated for patients with hyperpolinemia.
8. For treatment of primary humoral immunodeficiency, monitor IgG trough levels every 2 to 3 months before/after conversion from IV; subcutaneous infusions provide more constant IgG levels than usual IV immune globulin treatments.

LABS: ***(must check to order)***

- ☐ CBC with Auto Differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Complete Metabolic Set, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ IGG (serum), Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Labs already drawn. Date: _____

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NURSING ORDERS:

1. VITAL SIGNS – Assess vital signs before initiating IVIG infusion, at each rate increase, and then hourly after reaching max rate.
2. For intravenous immune globulins:
    a. IVIG Infusion Guidelines are available on the OHSU Pharmacy Services Intranet. See table for Infusion Guidelines. The rate of infusion may be increase only if no adverse reactions occur. Adventist follows package insert guidelines.
3. For subcutaneous immune globulin products:
    a. Hizentra is intended for subcutaneous administration using an infusion pump. Dose may be infused into multiple sites simultaneously.
    b. Hizentra subcutaneous injection sites: Abdomen, thigh, upper arm, lateral hip (avoid scars, stretch marks, and areas that are tender, bruised, red, or hard); <=8 simultaneous or <=12 consecutive injection sites in parallel (spaced >=2 inches apart). Cover infusion site(s) with a protective dressing after administration.
    c. Maximum infusion volume: First infusion: 15 mL per injection site (primary humoral immunodeficiency) or 20 mL per injection site (CIDP); subsequent infusions: 25 mL per injection site (primary humoral immunodeficiency) or 50 mL per injection site (CIDP).
    d. Maximum infusion rate: First infusion: 15 mL/hour per injection site (primary humoral immunodeficiency) or 20 mL/hour per injection site (CIDP); subsequent infusions: 25 mL/hour per injection site (primary humoral immunodeficiency) or 50 mL/hour per injection site (CIDP).
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)
Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

- ☐ acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
- ☐ diphenhydrAMINE (BENADRYL) capsule, 50 mg, oral, ONCE, every visit
- ☐ loratadine (CLARITIN) tablet, 10 mg oral, ONCE AS NEEDED, every visit, if diphenhydramine is not given. ***(Choose as alternative to diphenhydrAMINE if needed)***

MEDICATIONS:

INTRAVENOUS IMMUNE GLOBULIN:

- ○ **Gammagard 10% (OHSU & HMC preferred brand)**
- ○ **Privigen 10% (MCMC & Adventist preferred brand)**
- ○ **Gamunex-C 10%**

(Pharmacist will round dose to nearest 5 gram vial and modify brand selection based upon availability during order verification)

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SUBCUTANEOUS IMMUNE GLOBULIN

○ **Hizentra 20%**

Dose: ***(must check one)***

- ☐ 0.2 g/kg, ONCE
- ☐ 0.4 g/kg, ONCE
- ☐ 0.5 g/kg, ONCE
- ☐ 1 g/kg, ONCE
- ☐ _____ g, intravenous, ONCE

Interval: ***(must check one)***

- ☐ Once
- ☐ Daily x _____ doses
- ☐ Every _____ weeks for _____ doses

Specifications:

- ☐ Patient requires a specific brand of IG (other than those listed above)
  Please specify here: _____
- ☐ Patient requires intravenous IG at a 5% concentration

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

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By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

Please check the appropriate box for the patient's preferred clinic location:

☐ **Hillsboro Medical Center**
Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ **Adventist Health Portland**
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756

☐ **Mid-Columbia Medical Center**
Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610