LEGACY HEALTH	**Legacy Day Treatment Unit Provider's Orders** Adult Ambulatory Infusion Order INTRAVENOUS IMMUNE GLOBULIN (IVIG)	**Patient Name:** **Date of Birth:** **Med. Rec. No** (TVC MRN Only):
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE		

Anticipated Start Date: _____ **Patient to follow up with provider on date:** _____
*****This plan will expire after 365 days, unless otherwise specified below*****
Orders expire: _____

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis: _____ **Diagnosis Code:** _____

GUIDELINES FOR PRESCRIBING:

1. Send **FACE SHEET, INSURANCE CARD and most recent provider chart or progress note.**
2. In patients who may be at risk of renal failure, a decrease in dose, rate, and/or concentration should be considered. IVIG will be infused per Legacy Institutional Rate Guidelines, unless the rate is otherwise specified
3. If the preferred brand of IVIG (Privigen) is unavailable, or on short supply the pharmacist will interchange the product with another brand. Please specify if a patient cannot tolerate a specific brand
4. Pharmacist will round dose to the nearest 5 g vial to minimize waste
5. Ideal Body Weight (IBW) will be used to dose IVIG.
    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. If Actual Body Weight is less than IBW, use Actual Body weight to dose IVIG

LABS TO BE DRAWN (orders must be placed in TVC Epic by ordering provider if TVC provider):

- ☐ Basic Metabolic Set, Routine, ONCE, every _____(visit)(days)(weeks)(months) **Circle one**
- ☐ CBC with differential, Routine, ONCE, every _____(visit)(days)(weeks)(months) **Circle one**
- ☐ IGG, Serum, Routine, ONCE, every _____(visit)(days)(weeks)(months) **Circle one**
- ☐ Other: _____

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)

Note to provider: Please select which medication below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

Acetaminophen (TYLENOL) tablet oral, ONCE, every visit

☐ 325 mg ☐ 650 mg
☐ 500 mg ☐ 1000 mg

Diphenhydramine (BENADRYL) tablet oral, ONCE, every visit

☐ 25 mg
☐ 50 mg

Cetirizine (ZYRTEC) tablet oral, ONCE, every visit **(Choose as alternative to diphenhydramine if needed)**

☐ 10 mg

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MEDICATIONS: (must check at least one):

Intravenous Immune Globulin (IVIG) Privigen 10% (preferred brand): (Pharmacist will round dose to nearest 5 gm vial and modify brand/selection based upon availability during order verification)

- ☐ 0.2 g/kg IV, ONCE, every visit
- ☐ 0.4 g g/kg IV, ONCE, every visit
- ☐ 0.5 g/kg IV, ONCE, every visit
- ☐ 1 g/kg IV, ONCE, every visit
- ☐ _____ g IV, ONCE (for doses titrated to IgG level), every visit

Interval:

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

Specifications:

- ☐ Patient requires a specific brand of IVIG (other than listed above)

  Please specify here: _____

- ☐ Patient requires IVIG at a 5% concentration (note: currently not a standard stocked item)

Infuse per Legacy Immune Globulin Infusion Rate Guidelines (decrease rate of infusion in patients who may be at risk of renal failure) or specify rate below:

_____

_____

AS NEEDED MEDICATIONS:

- Acetaminophen 650 mg oral, EVERY 4 HOURS AS NEEDED for fever, headache or pain

NURSING ORDERS (TREATMENT PARAMETERS):

1. Vital signs, every visit: Assess vital signs before initiating IVIG infusion. During the first two infusions: assess vital signs at 15 minutes, 30 minutes, 1 hour, then hourly for remainder of infusion. For subsequent infusions: if the patient has been stable without adverse reactions, the frequency of vital signs is discretionary
2. Nursing communication order, every visit: Manage line per LH policy 904.4007 IV Catheter Insertion (Peripheral) and LH 904.4004 IV Access: Central Catheters
3. Nursing communication orders, every visit: Manage hypersensitivity reactions per LH 906.6606

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HYPERSENSITIVITY MEDICATIONS: Refer to LH policy 906.6606 Initiation of Emergency Measures for Adult Oncology, Radiation Oncology and Infusion Clinic Patients

1. Diphenhydramine 25-50 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. Famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. Hydrocortisone 100 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. Epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. Naloxone (Narcan) 0.4 mg IV, AS NEEDED x1 dose for diminished respiratory rate
6. Sodium chloride 0.9% 1000 mL IV, AS NEEDED x 1 dose for alteration in hemodynamic status
7. Meperidine 12.5-25 mg IV, AS NEEDED x 2 for infusion-related rigors
8. Nursing communication order, every visit: Please follow treatment algorithm for acute infusion reaction

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

☐ **Legacy Day Treatment Unit – The Vancouver Clinic Building**
A department of Salmon Creek Medical Center
700 NE 87th Avenue, Suite 360
Vancouver, WA 98664
Phone number: 360-896-7070
Fax number: 360-487-5773

☐ **Legacy Emanuel Day Treatment Unit**
A department of Emanuel Medical Center
501 N Graham Street, Suite 540
Portland, OR 97227
Phone number: 503-413-4608
Fax number: 503-413-4887

☐ **Legacy Salmon Creek Day Treatment Unit**
Legacy Salmon Creek Medical Center
2121 NE 139th Street, Suite 110
Vancouver, WA 98686
Phone number: 360-487-1750
Fax number: 360-487-5773

☐ **Legacy Silverton STEPS Clinic**
Legacy Silverton Medical Center
342 Fairview Street
Silverton, OR 97381
Phone number: 503-873-1670
Fax number: 503-874-2483

☐ **Legacy Woodburn STEPS Clinic**
A department of Silverton Medical Center
Legacy Woodburn Health Center
1475 Mt Hood Ave
Woodburn, OR 97071
Phone number: 503-982-1280
Fax number: 503-225-8723

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

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

Organization/Department: _____