(intravenous immunoglobulin)

IVIG Infusion Orders

NOVELLO INFUSION

Patient Name _____ DOB _____ Gender: ⬭ M ⬭ F

Phone_____

DIAGNOSIS: *Please provide IDC-10 Code*

- ☐ _____Primary Immunodeficiency (PI)
- ☐ _____Idiopathic Thrombocytopenic Purpura (ITP)
- ☐ _____Multifocal Motor Neuropathy (MMN)
- ☐ _____Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- ☐ _____Myasthenia Gravis
- ☐ _____Hypogammaglobulinemia
- ☐ _____(other)

PRE-MEDICATION:

- ☐ Tylenol 1000mg PO
- ☐ Cetirizine 10mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ _____Other
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____Other

IVIG ORDERS:

BRAND:

⬭ **Gamunex (10%)** ⬭ **Privigen (10%)** ⬭ **Octagam (10%)** ⬭ **Gammaplex (10%)**
⬭ **Gammagard (10%)** ⬭ **Flebogamma DIF (10%)** ⬭ **Gammaked (10%)** ⬭ _____ _____% **(other)**

DOSAGE:

⬭ _____**gm per day x** _____**days**
⬭ _____ **mg/kg over** _____**days**
● ***Emergency Orders and Treatment per Novello Infusion Anaphylaxis Policy***

PATIENT WEIGHT

_____**LBS**
_____**KG**

FREQUENCY:

⬭ **Every** _____**weeks**
⬭ **One time dose/treatment**

NOTES:

Nursing Orders

- Assess patient prior to each infusion
- Provide patient/caregiver education related to disease process, therapy, infection control, drug use, side effects and precautions, emergency plan
- Weigh patient every visit and record
- Monitor vital signs initially and throughout infusion per manufacturer recommendations
- Establish and maintain IV access / may use central venous access if appropriate and maintain per Novello policy
- Flush IV with 3ml-5ml of saline before and after every IV medication and PRN
- Administer infusion medication/injection as ordered
- If mild itching, slow down the infusion and monitor patient closely
- If anaphylactic reaction, stop infusion, implement emergency medications, and plan and call 911
- When infusion complete, flush IV with 3ml to 5ml saline flush or 50ml bag of saline and discontinue IV per INS Standards
- Evaluate effectiveness of infused therapy on disease process
- Lab work per physician when ordered

ORDERING PROVIDER:

Signature _____ **Printed Name:** _____**Date**_____

Practice _____**Phone**_____ **Fax** _____

****PLEASE FAX COMPLETED ORDER TO NOVELLO INFUSION 231-600-7058****

REV: 9/2021