Premier Health

Intravenous Immune Globulin (IVIG) Infusion Faxed Order Form

- **ALL Sections of this order form must be completed prior to scheduling in outpatient infusion center.**
- **Physician orders must be dated within 30 days of infusion.**
- **Non-EPIC providers must include a history and physical, any recent progress notes, AND relevant laboratory results supporting the medical necessity of IVIG (current within last 12 months)**

Infusion Center Fax numbers:

MVH Middletown 513-974-5023
MVH South 937-641-2676
MVH 937-641-2547
MVH North 937-641-2378
MVH Troy 937-440-4503
MVH Greenville 937-641-7205

Patient Name _____Date of Birth_____

Patient's Allergies _____

Patient's Actual Body Weight (in kg)_____Patient's Height_____ Date obtained_____

Patient's Insurance_____

Ordering Provider_____ Provider's Phone_____Fax #_____

PLEASE HAVE PATIENT BRING CURRENT MEDICATION LIST

Diagnosis (must include ICD-10 code):	❑ C91.10 Chronic lymphocytic leukemia of b-cell type not having achieved remission ❑ D80.1 Nonfamilial hypogammaglobulinemia D80.1 MUST ALSO INCLUDE: ❑ Z92.21 Personal history of antineoplastic chemotherapy ❑ D80.3 Selective deficiency of immunoglobulins ❑ D83.0 Common variable immunodeficiency w predominant abnormalities of B-cell numbers and function ❑ D83.9 Common variable immunodeficiency unspecified ❑ G35 Multiple sclerosis ❑ G61.81 Chronic inflammatory demyelinating polyneuritis ❑ G61.82 Multifocal motor neuropathy ❑ G70.00 Myasthenia gravis ❑ OTHER: _____ (Premier Prior Authorization team will do an evaluation to ensure the diagnosis code meets medical necessity requirements.)
For first doses	❑ Prior failed conventional therapies: _____
For continuation of therapy	❑ Patient has positive clinical response to prior infusions and continuation of therapy is necessary.

PHYSICIAN ORDERS

VITAL SIGNS:

- ❑ Vital signs at initiation, post rate titrations, and then hourly until completion
- ❑ Run IVIG in a dedicated line

INTRAVENOUS THERAPY:

- ❑ 0.9% NaCl 500mL, Intravenous CONTINOUS at 20ml/hr
- ❑ Custom rate:
  - 0.9% NaCl _____mL, Intravenous at _____ml/hr

Patient Name _____Date of Birth_____

- ❑ Saline flush panel
  - Saline flush IV push every 12 hours
  - Saline flush IV push PRN-as needed
- ❑ Heparin flush (100 units/ml) instill 500units PRN-as needed for implanted port de-access

PREMEDICATIONS: (check those preferred)

- ❑ Acetaminophen 650mg PO once- 30 minutes prior to starting infusion
- ❑ Antihistamines
  - DiphenhydrAMINE (BENADRYL) once- 30 minutes prior to starting infusion
    - ❑ 12.5mg
    - ❑ 25mg
    - ❑ 50 mg
      - PO
      - IV
- ❑ Steroid
  - MethylPREDNISolone (SOLU-MEDROL) IVP once- 30 minutes prior to starting infusion
    - ❑ 40mg
    - ❑ 80mg
    - ❑ 125mg
- ❑ Loop Diuretics
  - Furosemide (LASIX) 40mg once- prior to infusion
    - ❑ IV
    - ❑ PO
- ❑ Miscellaneous
  - _____

INTRAVENOUS IMMUNE GLOBULIN (IVIG):

- ❑ **Privigen (IVIG) (Preferred PH agent)**
- ❑ Gammagard (IVIG)
- ❑ Octagam (IVIG)
- ❑ Gamunex-C (IVIG)

DOSING AND FREQUENCY:

- _____mg/kg (All doses will be rounded to the nearest 5g vial)
  - Optional dose splitting on consecutive days
    - Please split dose over _____ days

  Weight-based dosing will be calculated using IBW for non-obese patients or AdjBW for obese patients. Obesity will be defined as BMI>30 or ABW 20%> than IBW. Patient who are <IBW will be dosed at actual body weight.

  OR

- _____ g (doses will not be rounded without a call to the provider)
  - Optional dose splitting on consecutive days
    - Please split dose over _____ days

This patient will receive IVIG treatment every _____ weeks. A new order must be submitted within 30 days of treatment.

Patient Name _____Date of Birth_____

ADMINISTRATION RATES - Medication will be administered at the specified rates listed below unless otherwise specified by the provider:

Privigen	Gammagard	Octagam	Gamunex-C
ITP: Initial: 0.5 mg/kg/minute (0.3 mL/kg/hour); Maintenance: Increase by 0.3mL/kg/hr every 15 min (if tolerated) up to 4 mg/kg/minute (2.4 mL/kg/hour). **CIDP/Primary humoral immunodeficiency**: Initial: 0.5 mg/kg/minute (0.3 mL/kg/hour); Maintenance: Increase by 0.3mL/kg/hr every 15 min (if tolerated) up to 8 mg/kg/minute (4.8 mL/kg/hour).	**Multifocal motor neuropathy:** Initial: 0.8 mg/kg/minute (0.5 mL/kg/hour); Maintenance: Increase by 0.5ml/kg/hr every 15 min (if tolerated) up to 9 mg/kg/minute (5.4 mL/kg/hour). **Primary humoral immunodeficiency:** Initial (first 30 minutes): 0.8 mg/kg/minute (0.5 mL/kg/hour); Maintenance: Increase by 0.5ml/kg/hr every 15 min (if tolerated) up to up to: 8 mg/kg/minute (5 mL/kg/hour).	**Dermatomyositis:** Initial (first 30 minutes): 1 mg/kg/minute (0.6 mL/kg/hour); Maintenance: Double infusion rate (if tolerated) every 30 minutes up to a maximum rate of 4 mg/kg/minute (2.4 mL/kg/hour). **ITP:** Initial (first 30 minutes):1 mg/kg/minute (0.6 mL/kg/hour); Maintenance: Double infusion rate (if tolerated) every 30 minutes up to a maximum rate of 12 mg/kg/minute (7.2 mL/kg/hour).	**CIDP:** Initial (first 30 minutes): 2 mg/kg/minute (1.2 mL/kg/hour); Maintenance: Increase by 1.2ml/kg/hr every 30 min (if tolerated) to a maximum of 8 mg/kg/minute (4.8 mL/kg/hour). **Primary humoral immunodeficiency or ITP:** Initial (first 30 minutes): 1 mg/kg/minute (0.6 mL/kg/hour); Maintenance: Increase by 1.2ml/kg/hr every 30 min to a maximum of 8 mg/kg/minute (4.8 mL/kg/hour).

ITP: Immune Thrombocytopenia CIDP: Chronic Inflammatory Demyelinating Polyneuropathy

- ❑ **Physician specified**
  - Initial (first 30 minutes): _____mg/kg/minute (_____mL/kg/hr); Maintenance: Increase by _____mg/kg/minute every _____ minutes (if tolerated) to a maximum of _____mg/kg/minute (_____ mL/kg/hr).

MILD/MODERATE INFUSION RELATED REACTION:

- ✓ For Mild/Moderate Infusion Reaction- stop infusion. Maintain vascular access. Monitor vitals every 10 minutes. Once symptoms resolve, infusion may be restarted at ordered rate.
- ✓ Diphenhydramine 25mg IVP once as needed for itching/hive for mild/moderate reactions.

EMERGENCY MEDICATIONS (Anaphylaxis/Severe infusion reaction):

- ✓ Contact provider for Emergency or Severe/Anaphylactic Reaction
- ✓ For Anaphylaxis/Severe Reaction, Immediately discontinue drug infusion. Place patient in supine position. Assess airway, breathing, circulation, and mentation. Monitor vital signs (including O2 saturation every 5 minutes).
- ✓ For Anaphylaxis/ Severe reactions, Administer oxygen per nasal cannula or mask as needed to maintain O2 saturations >90%
- ✓ Epinephrine 1:1000 0.3mg IM every 5 minutes X3 PRN for severe reaction/anaphylaxis
- ✓ Diphenhydramine 50mg IVP once PRN for severe reaction/anaphylaxis
- ✓ Famotidine 20mg IVP once PRN for severe reaction/anaphylaxis
- ✓ Methylprednisolone 125mg IVP once PRN for severe reaction/anaphylaxis
- ✓ 0.9% NaCl 1000mL continuous PRN for severe reaction/anaphylaxis at 999mL/hr until symptoms resolve

Provider signature_____

Printed provider name_____

Date_____ Time _____

***Please note this order is only valid for 30 days after signature** **12-18-2023 version**