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 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

LABS:

- ❑ CBC
- ❑ IGG
- ❑ CMP
- ❑ IGG subclass 1-4
- ❑ Renal Panel

Patient Name ____Date of Birth___________________________

INTRAVENOUS THERAPY:

- ❑ 0.9% NaCl 500mL, Intravenous CONTINOUS at 20ml/hr
- ❑ Custom rate:
  - 0.9% NaCl ________mL, Intravenous at ________ml/hr
- ❑ Saline flush panel
  - Saline flush IV push every 12 hours
  - Saline flush IV push PRN-as needed

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 ❑ 50mg
    - ❑ 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)
- ❑ Other: ____

DOSING (All doses will be rounded to nearest 5g vial) **AND FREQUENCY:**

- **__________grams** **<u>OR</u>** **__________mg/kg**
  - 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.

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
1. For first time administration, or for patients who had problems tolerating IVIG infusion previously: Start at 30 ml/hr for 30 minutes, then increase by 30 ml/hr every 15 minutes, as tolerated, to a maximum rate of 150 ml/hr. 2. For patients who have tolerated previous infusions: Start at 50 ml/hr for 30 minutes, then increase by 30 ml/hr every 15 minutes, as tolerated, to a maximum rate of 200 ml/hr.	1. For first time administration, or for patients who had problems tolerating IVIG infusion previously: Start at 30 ml/hr for 30 minutes, then increase by 30 ml/hr every 15 minutes, as tolerated, to a maximum rate of 200 ml/hr. 2. For patients who have tolerated previous infusions: Start at 50 ml/hr for 30 minutes, then increase by 30 ml/hr every 15 minutes, as tolerated, to a maximum rate of 350 ml/hr.	1. For first time administration, or for patients who had problems tolerating IVIG infusion previously: Start at 40 ml/hr for 30 minutes, then increase by 40 ml/hr every 15 minutes, as tolerated, to a maximum rate of 350 ml/hr. 2. For patients who have tolerated previous infusions: Start at 50 ml/hr for 30 minutes, then increase by 40 ml/hr every 15 minutes, as tolerated, to a maximum rate of 500 ml/hr.	1. For first time administration, or for patients who had problems tolerating IVIG infusion previously: Start at 40 ml/hr for 30 minutes, then increase by 40 ml/hr every 15 minutes, as tolerated, to a maximum rate of 200 ml/hr. 2. For patients who have tolerated previous infusions: Start at 50 ml/hr for 30 minutes, then increase by 40 ml/hr every 15 minutes, as tolerated, to a maximum rate of 300ml/hr.
3. If patient experiences adverse reaction during infusion, slow or stop infusion. If symptoms subside promptly, the infusion can be resumed/maintained at a lower rate that is comfortable for the patient.			

- ❑ **Physician specified**
  - Start at ___________ml/hr for 30 minutes, then increase by __________ ml/hr every 15 minutes, as tolerated, to a maximum rate of __________ ml/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** **03-21-2024 version**