LOUIS H. MEDVED, MD
INFUSION THERAPY

Patient Name:

DOB:

Intravenous Immunoglobulin (IVIG) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ Primary Humoral Immunodeficiency (ICD-10)

_____ Multifocal Motor Neuropathy (ICD-10)

_____ Chronic Inflammatory Demyelinating Polyneuropathy (ICD-10)

_____ Other: _____ (ICD-10)

Nursing Orders:

- Monitor vital signs every 30 minutes and with each rate change.
- Administration guidelines vary by IVIG product and brand. Review manufacturer instructions for infusion rate, titration schedule and filtration requirements.
- If infusion-related reaction occurs, stop infusion, and follow Hypersensitivity Reaction Management Policy/Protocol as clinically indicated.

Pre-medications:

☑ **Tylenol 1000 mg PO** ☑ Benadryl 25 mg IV ☑ **Solu-medrol 125 mg IVP**

☐ **Loratadine 10 mg PO** ☐ Other:

Administer IVIG _____g/kg x current weight (_____ kg) = _____ g

☐ Brand name medically necessary; dispense only _____

Dose may be rounded by up to 10% to nearest vial size per protocol. Provider check here (☐) to PROHIBIT dose rounding.

☐ Administer as a single infusion ☐ Divide dose over _____ days

Frequency:

☐ Every _____ weeks ☐ Every _____ months

☐ Once ☐ Other: _____

Hydration (optional)**:**

☐ Infuse 500 ml NS over 30 min pre- or post-infusion PRN hydration or headache

☐ Other:

Provider (please print): _____

Provider signature: _____ Date: _____

Revised 10/24/19. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.