IVIG - GAMMAGARD LIQUID 10% (IMMUNE GLOBULIN)

Infusion therapy plan orders

Patient: _____ **DOB:** _____

Infusion Therapy:

Medication: Immune globulin-human (GAMMAGARD LIQUID) 10% IV infusion

Dose: _____ grams/dose (round to the nearest 1 gm)

Route: Intravenous

Frequency:

☐ daily x 2 doses ☐ every _____ weeks x 6 months

☐ daily x 4 doses ☐ other: _____

Provider Information:

- Infusion rates should not go beyond 3.3 mg/kg/min for
  - Patients at risk for thrombotic event
  - Patients with underlying renal insufficiency or those at risk for developing renal insufficiency

Infusion rate:

Standard infusion rate: begin rate at 0.8 mg/kg/min (0.5 mL/kg/hr) for 30 minutes, then if tolerated increase rate every 30 minutes as follows: 2 mg/kg/min, then 4 mg/kg/min, then 6 mg/kg/min, **then to max rate of:**

☐ 8 mg/kg/min (5 mL/kg/hr)

☐ 3.3 mg/kg/min (<2 mL/kg/hr) ***Max rate for pre-existing renal insufficiency or thrombotic risk***

OR

☐ alternative infusion instructions:_____

Premedications:

☐ acetaminophen 650 mg tablet, PO, Once, 30 minutes prior to IVIG infusion (if not taken at home)

☐ cetirizine 10 mg tablet, PO, Once, at least 60 minutes prior to IVIG infusion (if not taken at home)

☐ diphenhydramine 25 mg tablet, PO, Once, at least 30 minutes prior to IVIG infusion (if not taken at home)

☐ Other: _____

☐ No routine pre-medications necessary.

Patient Education:

☐ Documentation in the patient record that the potential risks have been explained, the patient has been given the opportunity to ask questions and has given consent to receiving IVIG therapy.

Provider Signature: _____ **Date:** _____

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

SKYLINE HOSPITAL