



INFUSION SUITE		IVIG INFUSION ORDERS	
Durango Infusion Center 270 E 8th Ave Ste N101 Durango, CO 81301		Phone: 970-828-3500	Fax: 970-828-3501
<b>PATIENT INFORMATION - Include Patient Demographics and Insurance Cards</b>			
Name:		DOB:	
<b>MEDICAL INFORMATION</b>			
ICD10:		Patient Height:	
Patient Weight (kg):		Allergies:	
*Weigh patient prior to each infusion			
<b>REQUIRED TESTING</b>			
<input type="checkbox"/> IgA antibodies:	<input type="checkbox"/> BUN/Creatinine:	*IgA required prior to initiation	
<b>Additional labs:</b>			
<input type="checkbox"/> Insert IV	<input type="checkbox"/> Access Port/PICC		
<b>PREMEDICATIONS 30 minutes prior to starting</b>			
<input type="checkbox"/> Acetaminophen:	<input type="checkbox"/> 325mg PO X1	<input type="checkbox"/> 500mg PO X1	<input type="checkbox"/> 650mg PO X1 <input type="checkbox"/> 1000mg PO X1
<input type="checkbox"/> Diphenhydramine:	<input type="checkbox"/> 25mg IV X1	<input type="checkbox"/> 25mg PO X1	<input type="checkbox"/> 50mg IV X1 <input type="checkbox"/> 50mg PO X1
<input type="checkbox"/> Solumedrol:	<input type="checkbox"/> 40mg IV X1	<input type="checkbox"/> 100mg IV X1	<input type="checkbox"/> 125mg IV X1
<input type="checkbox"/> Antihistamine:	<input type="checkbox"/> Cetirizine 10mg PO X1	<input type="checkbox"/> Loratadine 10mg PO X1	
<input type="checkbox"/> Additional PRN:			
<b>IVIG ORDERS</b>		<input type="checkbox"/> NO BRAND PREFERENCE	
<input type="checkbox"/> GAMUNEX-C	<input type="checkbox"/> GAMMAKED	<input type="checkbox"/> BIVIGAM	<input type="checkbox"/> GAMMAGARD
<input type="checkbox"/> PANZYGA	<input type="checkbox"/> OCTAGAM	<input type="checkbox"/> PRIVIGEN	<input type="checkbox"/> OTHER: _____
<input type="checkbox"/> Loading: _____ g/kg total over _____ days OR _____ g per day x _____ days (_____ total grams)			
<input type="checkbox"/> Subsequent: _____ g/kg IV OR _____ g over _____ Days every _____ weeks X _____ (_____ grams per day)			
<b>POST INFUSION</b>			
<input type="checkbox"/> Flush IV line with 25mL NS at the same rate of infusion. D/C IV.			
<input type="checkbox"/> Flush IV line with 25 mL NS. Flush port with 10mL NS, Lock port with 5mL Heparin 10-100U/mL and deaccess			
<input type="checkbox"/> Discharge home		<input type="checkbox"/> May keep IV or port access for successive treatments	
Referring Provider Printed:		NPI:	
Referring Provider Signature:		Date:	
Referring Provider Phone:		Referring Provider Fax:	
DNG Provider Printed:			
DNG Provider Signature:		Date:	

\*Credentials must be included

**Infusion Directions:**

- Remove vial and allow to come to room temp before administration
- Hang vials from smallest vial to largest vial (least quantity to largest quantity)
- Discard and document any drug waste
- Infuse per PI/titration table

**Nusing Considerations:**

- IgA-deficient patients with antibodies against IgA are at greater risk of developing severe hypersensitivity and anaphylaxis
- Monitor glucose levels in diabetic patients with a glucose-specific method only.