ALL ORDERS MUST BE SIGNED AND DATED BY THE REFERRING PROVIDER

ALLERGIES/REACTIONS (REQUIRED):

Yakima Outpatient Infusion Care
808 N 39th Ave Yakima WA 98902
Phone: 509-575-1174
Fax: 509-577-5021

ORDERS WITH CHECK BOXES	When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order; orders left unchecked will not be initiated.
CODE STATUS	Patients will be considered FULL CODE unless marked otherwise. If the patient has a POLST, advance directive, or living will, please include a copy with the orders.

IMMUNE GLOBULIN (IVIG)

Patient Name:_____ Requested Start Date: _____/_____/_____

Date of Birth:_____/_____/_____ Patient Weight: _____ kg Patient Height: _____

DIAGNOSIS & ICD-10 CODE: _____

REQUIRED: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with this order, scheduling of treatment will be delayed until complete information is available

LABS:

- ☑ CMP & CBC prior to the first infusion and every _____ weeks thereafter (default 12 weeks)
  Call provider if SCr increases > 50% from baseline and/or SCr > 1.5 mg/dL
- ❑ Other (specify requested labs and frequency): _____

ACCESS: *Access and maintain IV site or Port-A-Cath in accordance with the appropriate MYMH OIC P&Ps*

TREATMENT: *(another brand of drug, identical in form and content may be dispensed unless "DAW" or "BRAND ONLY" is written next to the drug name; formulary subject to change)*

- ✓ **PRE-MEDICATIONS** – give 30 minutes prior to infusion
  - ✓ Acetaminophen 650 mg PO x 1 dose
  - ✓ Diphenhydramine 25 mg PO x 1 dose or loratadine 10 mg PO x 1 if intolerant to diphenhydramine

- ✓ **TREATMENT REGIMEN** – IVIG Product **Note: brand names are subject to change with an equivalent product—formulary subject to change**
  - ❑ Gammagard Liquid 10% IV
  - ❑ Other Product (subject to availability): _____
  - ❑ Dose per pharmacy: _____ g/kg/day IV daily for _____ days every _____ weeks (round to nearest 5 g)
    OR
  - ❑ Dose per referring provider: _____ g/day IV daily for _____ days every _____ weeks (round to nearest 5 g)

MONITORING: 1st infusion: vital signs every 30 minutes x 2 then every hour until infusion is complete.
2nd infusion: vital signs within 30 minutes then every 4 hours until infusion is complete.

SUPPORTIVE CARE: Administer hypersensitivity reaction/anaphylaxis management per MYMH OIC protocol as necessary.

DISCHARGE: 30 minutes after infusion is complete when vital signs are stable and hypersensitivity symptoms are absent. Waiting period can be waived by patient on subsequent infusions.

Provider Signature: _____ Date: _____
Print name: _____ Phone # _____ Fax # _____

**** FOR PHARMACY USE ONLY – PHARMACY TO DOSE IVIG BASED ON G/KG ****

Total Body Weight (TBW): _____ kg Ideal Body Weight (IBW): _____ kg Adjusted Body Weight (AjBW): _____ kg (If ABW > 30% IBW)

Dosing Weight: ❑ TBW ❑ IBW ❑ AjBW *(If TBW < IBW – use IBW; If TBW > 30% IBW use AjBW; otherwise use IBW)*

Calculated Dose: _____ g Rounded Dose: _____ g (dose to be administered)

Pharmacist Signature: _____ Date: _____

❑ NEW REFERRAL ❑ UPDATED REFERRAL ****Expires 12 months from written date****

Patient Identification - Attach Patient Label

Name:

MRN:

Age / Sex and Gender:

IMMUNE GLOBULIN (IVIG)

MultiCare

Yakima Memorial Hospital