

## Intravenous Immune Globulin (IVIG) Order Form

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Patient Name Middle Last DOB

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Diagnosis Diagnosis Code

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Height (cm) Actual Weight (kg) Allergies

### PREMEDICATION - ADMINISTER IF PATIENT HAS NOT ALREADY TAKEN:

\*In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.

- None
- Acetaminophen 1000 mg orally x 1 dose prior to IVIG
- Diphenhydramine 25 mg IV x 1 dose prior to IVIG (pt will need a driver home)
- Diphenhydramine 50 mg IV x 1 dose prior to IVIG (pt will need a driver home)
- Other: \_\_\_\_\_

### DOSE: ROUND TO NEAREST 5 GM DOSE.

\*The preferred IVIG at New England Cancer Specialists is Gamunex-C 10%.

\*If a different IVIG product is needed, indicate the brand and clinical rationale below.

- Gamunex-C 10% \_\_\_\_\_ g/kg (J1561)
- Other: \_\_\_\_\_

**Total IVIG Dose = WT (kg) x Dose (g/kg) = \_\_\_\_\_**

Rate of Infusion IVIG will be infused according to NECS standard unless otherwise ordered.

- Other: \_\_\_\_\_

### FREQUENCY OF ADMINISTRATION

- x 1 dose only
- Weekly x \_\_\_\_\_ doses
- Other: \_\_\_\_\_
- Daily x \_\_\_\_\_ doses
- Monthly x \_\_\_\_\_ doses

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Provider Name

Provider Signature

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Date

Phone

Fax

Pager