LOWER UMPQUA HOSPITAL
OUTPATIENT NURSING DEPARTMENT
600 Ranch Road, Reedsport, OR 97467
For Referrals: (541) 271-2163 – Press #3 (all other services) then press # 2 (Referrals)
For Outpatient Nursing: (541) 271-2171 ext. 5205
FAX: (541) 271-5433

Immune Globulin (Intravenous Infusion) Therapy

Patient Name _____ **DOB** _____

Patient Phone # _____ **Patient Weight (Kg)** _____ **Patient Height (cm):** _____

Patient Allergies _____

Provider _____ **NPI#** _____

ICD-10 Code (REQUIRED) _____ **J Code** _____

Primary Diagnosis _____

Secondary Diagnosis _____

Duration (or # of treatments): _____ **Anticipated Infusion Date** _____

INSTRUCTIONS TO PROVIDER

- ***Please ensure insurance authorization has been initiated.***
- *This plan will expire **after 365 days,** at which time new orders will need to be placed.*

ORDERING GUIDELINES

- Send **FACE SHEET and H&P or most recent chart note.**
- In patients who may be at risk of renal failure, a decrease in dose and rate should be considered. Consider MAXIMUM rate of 2 mL/Kg/hour for the 10% solution. Avoid use in patients with CrCl **less than** 10 mL/minute

MEDICATIONS

Pre-medications

☒ **acetaminophen** (*TYLENOL*) 650 mg PO PRN pre-medication **x** 1 dose - Administer 60 minutes prior to infusion
☒ **diphenhydrAMINE** (*BENADRYL*) 25 mg IV PRN pre-medication **x** 1 dose - Administer 30 minutes prior to infusion

Hydration/ Maintenance TKO

☒ **dextrose 5%** (D5W) IV at 25 mL/hour once PRN per facility policy - flush/hydration/main bag/TKO

Immune Globulin, Intravenous Infusion

{Choose ONE}

☐ **Preferred: Gammagard Liquid 10% Solution**
☐ **Alternative** *(provide specialty brand and reason):*_____

☒ **Dose:** _____ gram(s) / day **for** _____ day(s)
Note: Daily dosing to be rounded to nearest 5 grams

Date _____ Time _____ Provider Signature _____

"Statement of Responsibility of Parties: referring Prescriber agrees that in referring patients to Lower Umpqua Hospital Outpatient Nursing Department, the responsibility for the care related to these Outpatient Nursing Therapy Plan orders, as well as administration of any 340B drugs, remains with Lower Umpqua Hospital."

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- Maximum daily dose = 1 gram / Kg / day
- TOTAL dose can be divided over 2 to 5 consecutive days.
- Adjusted body weight (BW) should be used for dosing when Actual BW is **greater than** 130% of Ideal BW (IBW). Otherwise, IBW or Actual BW should be used for dosing, whichever is lowest.
- Pharmacy to select and purchase appropriate vial sizes to achieve total ordered Gram dose while minimizing medication waste.

☒ **Infusion Rate:** Start at 0.5 mL/Kg/hour = 0.8 mg/Kg/minute **x** 30 minutes. Double the rate every 30 minutes, if tolerated, up to 5 mL/Kg/hour (8 mg/Kg/minute)

VITAL SIGNS (VS)

☒ Vital signs before initiating infusion, at each rate increase, then Q1 hour until infusion is completed. Then, VS 30 minutes after infusion completed.

LABS

☐ _____

☐ _____

☐ _____

LINE CARE MAINTENANCE

☒ Follow facility policies/procedures for all vascular access maintenance with appropriate flush solutions, de-clotting (**alteplase**), and/or dressing changes

☒ **alteplase** *(CATHFLO ACTIVASE)* injection 2 mg/2 mL intra-catheter **x** 1 PRN de-clotting **x** 2 doses

☒ **heparin, porcine - Preservative Free (PF)** 100 units/mL IV syringe 500 units intra-catheter **x** 1 PRN line care

☒ **0.9% sodium chloride** 10 mL IV flush PRN as needed

☒ If applicable, may remove PICC line at the completion of course of therapy

EMERGENCY MEDICATIONS FOR HYPERSENSITIVITY / INFUSION REACTION

** *Itching, hives, fever* **

☒ **STOP MEDICATION INFUSION if allergic reaction occurs**

☒ Establish IV access and infuse **0.9% sodium chloride** 500 mL at 25 mL/hour PRN Hypersensitivity / Allergic reaction

☒ VS Q15 minutes **x** 4 and PRN

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EMERGENCY MEDICATIONS FOR HYPERSENSITIVITY / INFUSION REACTION, continued

- ☒ **acetaminophen** *(TYLENOL)* 650 mg PO Q4 hours PRN Hypersensitivity / Allergic Reaction.
- ☒ **diphenhydramine** *(BENADRYL)* 25 mg IVP PRN Hypersensitivity / Allergic Reaction **x** 1 dose. May repeat **x** 1 ***{Maximum dose = 50 mg}***
- ☒ **NOTIFY** Provider of Hypersensitivity / Allergic Reaction
- ☒ **hydrocortisone** 100 mg IVP PRN Hypersensitivity / Allergic Reactions **x** 1 dose if reaction continues and is not relieved by maximum dose of **diphenhydramine**

ANAPHYLAXIS REACTION

******** *Wheezing, Dyspnea, Hypotension, Angioedema, Chest pain, Tongue swelling* ********

- ☒ Transfer to Emergency Department (ED) as needed, and **NOTIFY** Provider
- ☒ **epinephrine** 0.3 mg IM PRN anaphylaxis **x** 1 dose

Date _____ Time _____ Provider Signature _____

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