MAYO CLINIC

Intravenous Immune Globulin (IVIG) Administration

Orders apply to all patients.
Mark the ☒ for desired orders. If ☐ are blank, order is inactive.

Clinic Number

Name

Room Number

Height: _____ cm Weight: _____ kg Age: _____
Allergy module reviewed. ☐ No additional allergies identified, **or**
Choose one: ☐ Additional allergies identified and MICS Allergy updated, **or**
☐ Additional allergies. List (include reaction): _____ please update MICS Allergies.

☐ Adult Patient ☐ Pediatric
☐ Infusion Therapy Center ☐ Pediatric Infusion Therapy Center ☐ Other _____

ALERTS

- **Pharmacy will not dispense medication if information below is not fully completed.**
- Order is valid for one course of therapy only.
- For administration in Infusion Therapy Center (ITC) complete both ITC Request Form MC2080 and IVIG Orders.
- For administration in Pediatric Infusion Therapy Center (ITC) complete both ITC Pediatric Request Form MC2080-01 and IVIG Orders.

INDICATION: Refer to Mayo Pharmaceutical Formulary Committee (MPFC) algorithm on reverse.
Indication level : (check one) ☐ I ☐ II ☐ III List indication here: _____

– OR –

Other indication if not listed in MPFC algorithm. Must provide at least one reference from literature, and **obtain prior authorization from Staff Consultant recommending IVIG therapy.** Printed name of Staff Consultant: _____ Pager: _____

☐ List indication here: _____
Reference: _____

INFUSION: (Indicate product choice and dose.)

IVIG Product choices:

☐ Carimune™ 10%. [For patients age 15 years and older, Pharmacist will round final total dose to nearest increment of 3 grams.]
☐ POLYGAM® S/D, 10% (restricted to IgA deficient patients, and/or patients with documented reaction to Carimune™). [For patients age 15 years and older, Pharmacist will round final total dose to nearest increment of 5 grams.]
☐ Gamunex®, 10% (Restricted to Kidney Transplant service). [For patients age 15 years and older, Pharmacist will round final total dose to nearest increment of 5 grams.]
☐ Other: (Indicate Brand Name of Non-Formulary Product) _____.

For Inpatient and Hospital Based Outpatient use: (Indicate dose and duration).
☐ Immune Globulin _____ grams IV once every _____ day(s) for _____ doses.

For Outpatient use (e.g. ITC): (Indicate dose and duration).
☐ Immune Globulin _____ grams IV every _____.
(Frequency and duration. Maximum duration of 1 year.)

Infuse per standard infusion instructions below.

Standard Adult Infusion Instructions	**Standard Pediatric Infusion Instructions**
Start infusion at 1 mL/minute for 30 minutes.	Start infusion at 0.01 mL/kg/minute for 30 minutes.
Then increase to 2 mL/minute for 30 minutes.	Then increase to 0.02 mL/kg/minute for 30 minutes.
Then increase to 3 mL/minute for 30 minutes.	Then increase to 0.04 mL/kg/minute for 30 minutes.
Then increase to 4 mL/minute for 30 minutes.	Then increase to 0.06 mL/kg/minute for 30 minutes.
Then may increase to a maximum rate of 5 mL/minute as tolerated until infusion complete.	Then may increase to maximum rate of 0.08 mL/kg/minute as tolerated until infusion complete.
Solution MUST be room temperature for administration.	**Solution MUST be room temperature for administration.**
Use dedicated IV line for administration.	**Use dedicated IV line for administration.**

PRE-MEDICATIONS:

Drug(s)/Dose/Route/Frequency/Indication	Drug(s)/Dose/Route/Frequency/Indication

ADDITIONAL ORDERS:

- Monitor heart rate, respiratory rate, blood pressure, and temperature prior to starting infusion and every 30 minutes for 1 hour and then hourly until infusion complete.

Stop Infusion and notify Ordering Service for:

- Heart rate greater than _____ or less than _____.
- Respiratory rate greater than _____ or less than _____.
- Temperature greater than _____ degrees Celsius.
- Systolic blood pressure greater than _____ or less than _____ mmHg.
- Skin reaction or patient complaint of chest pain.

Prescriber's Signature: _____ Prescriber's Pager #: _____ Service Pager #: _____
Prescriber's Printed Name: _____ Date: mm/dd/yyyy Time: hh:mm (24 hour clock)

Part 1 – Pharmacy Part 2 – Nursing Part 3 – Order Book

This order set has been developed to reflect the practice patterns of the clinicians who wrote it. It sets forth recommendations as to practice, not rigid rules.

Mayo Pharmaceutical Formulary Committee Algorithm - Indication Levels

Level I. First line treatment agent for:

1. Replacement therapy for primary immune deficiency states including common variable immune deficiency, functional specific antibody deficiency IgG subclass deficiency (except IgG3) ataxia telangiectasia with hypoglobulinemia and recurrent infections. Wiskott-Aldrich Syndrome with infections, severe combined antibody deficiency before and after bone marrow transplantation
2. Secondary Immune deficiency states (post transplant antibody deficiency and CLL-associated antibody deficiency and other hematopoetic malignancies)
3. Toxic epidermal necrolysis, Severe erythema multiforme, Stevens-Johnsons syndrome
4. Acute idiopathic thrombocytopenic purpura (ITP)
5. Chronic ITP
6. Pediatric HIV
7. Kawasaki's disease
8. Infection prophylaxis or Ig replacement in B-cell chronic lymphocytic leukemia
9. Treatment of antibody mediated rejection of kidney transplant
10. Neonatal sepsis
11. Positive crossmatch kidney transplant
12. Treatment of recurrent focal segmental glomerulosclerosis in kidney transplantation
13. Acute and chronic inflammatory demyelinating polyradiculoneuropathy (CIPD) – idiopathic or associated with monoclonal gammopathy of undetermined significance (MGUS) – including Guillain-Barre Syndrome (GBS)
14. Autoimmune neuropathies (including multifocal motor neuropathy with conduction block , anti-myelin associated glycoprotein (MAG) sensory-motor neuropathy, radiculoplexus and autoimmune autonomic neuropathy)
15. Myasthenia Gravis – acute exacerbation & pre-thymectomy

Level II. Second line treatment agent or adjunctive treatment agent for:

1. Multiple sclerosis and autoimmune demyelinating encephalomyelitis (ADEM)
2. Inflammatory myopathies (dermatomyositis, polymyositis)
3. Pure red cell aplasia, with documented parvovirus B10 infection and severe anemia
4. Autoimmune hemolytic anemia (warm type) unresponsive to glucocorticoids
5. Necrotizing fasciitis
6. Biopsy proven viral myocarditis
7. Coombs – positive neonatal jaundice
8. Lambert-Eaton Myasthenia Syndrome
9. Stiff-Person's Syndrome
10. Paraneoplastic Neurological Disorders
11. Dermatomyositis

Level III. To be used only after documented failure of at least 2 previous therapeutic options with severe disease or when other treatments are contraindicated:

1. Immune mediated neutropenia
2. Immune thrombocytopenia, refractory to platelet transfusion, for whom other modalities are unsuccessful or contraindicated.
3. Autoimmune connective tissue diseases including systemic vasculitis, systemic lupus erythematosis, severe cutaneous immunobullous diseases, pyoderma gangrenosum
4. Myasthenia gravis – maintenance therapy
5. Neonatal alloimmune thrombocytopenia in severly affected neonates
6. Rituximab (Rituxin) treatment with recurrent B cell associated infection
7. Intractable epilepsy caused by: Landau-Kleffner, Rasmussen's encephalitis or other epilepsies related to an underlying autoimmune etiology

Level IV. Requires prior authorization:

All other indications