Saskatoon Health Region

☐ RUH ☐ SCH ☐ SPH
☐ OTHER: _____

PATIENT IDENTIFICATION

Intravenous Immune Globulin (IVIG) Infusion Order Set - ADULT

ACTION			
MAR	ICP	REQ	RN

Infusion Location

☐ Inpatient Care Area: _____ ☐ Outpatient Care Area: _____

Clinical Information

☒ Indication for IVIG: _____
☒ Physician recommending IVIG: _____ Specialty: _____
☒ History of previous IVIG Adverse Reaction: ☐ No ☐ Yes (describe below)
_____

Lab Investigations Pre-Infusion (if applicable and as ordered by physician)

☒ ABO Group/Rh Type – *prior to first infusion only* (complete Transfusion Medicine Test Request Form)
☐ CBC: frequency _____ ☐ Creatinine: frequency _____ ☐ Immunoglobulins (IgA, IgM, IgG): frequency _____
☐ Additional Labs (see attached orders **OR** completed laboratory requisition)

IV Therapy

IV Fluid: ☒ D5W at TKVO (30 mL/h)

Pre-Medication (if applicable, due to history of documented adverse reaction)

☐ _____ ☐ _____
☐ _____ ☐ _____

Medications

☐ acetaminophen 325-650 mg PO x 1 PRN for febrile reaction
☐ dimenhy**DRINATE** 25-50 mg PO or IV x 1 PRN for nausea
☐ ondansetron 4 mg PO or IV x 1 PRN for nausea
☐ diphenhydr**AMINE** 25-50 mg PO or IV x 1 PRN for itch or rash. If severe symptoms, **call ordering MD**
☐ _____

IVIG Dose (Adjusted body weight calculator: pbco.ca/IVIG_Dosing_Calculator.htm)

☒ Actual Weight (kg) _____ ☒ Height (cm) _____ ☒ **Calculated Dosing Weight (kg)** _____
NOTE: Use the calculator for clinically obese patients, valid for weight 20-200 kg AND height 153-241 cm.
Contact the Transfusion Medicine Physician (TMP) on call for patients over 200 kg or if there are any dosing questions.
☐ If actual body weight dose ordered, indicate reason (required) _____
☐ Specific IVIG Brand _____ Reason (required): _____
☐ IVIG dose/kg: _____ g/kg ☐ Total IVIG dose ordered: _____ g (round up to nearest 5 g)

IVIG Administration

☐ IVIG _____ g IV x 1 dose **OR**
☐ IVIG _____ g IV daily x _____ days. Repeat every _____ weeks x _____
☐ Maximum rate not to exceed 4 mL/kg/h due to risk of acute renal dysfunction
(e.g. pre-existing renal dysfunction, age over 65, sepsis, hypovolemia, paraproteinemia, concurrent nephrotoxic medications)

NOTE: This order expires 6 months from the date of completion.
Complete Plasma Protein Product Request (Form #103221) and fax to TML each time IVIG is requested.

PRACTITIONER PRINTED NAME | PRACTITIONER SIGNATURE | DATE/TIME

PATIENT IDENTIFICATION

ADULT 10% IVIG INFUSION RATE TABLE

Applies to all 10% IVIG solutions. Select the "blood IVIG 10 % Pilot" line in the Smart Pump Drug Library.

- For patients below, at, or near their ideal body weight, the "dosing weight" is the patient's actual weight. For obese patients (i.e. actual weight more than 20% above ideal weight or BMI over 30 kg/m^2), the dosing weight is a calculated weight that is the mathematical average of the actual and the ideal body weight. See http://pbco.ca/IVIG_Dosing_Calculator.htm
- Slower rates reduce the frequency and severity of common side effects associated with IVIG infusion such as rigors, fever, headaches, nausea, changes in blood pressure or HR. **Consider rate reduction as the first step towards management of these symptoms.** Infusion may be ordered at a reduced rate at the discretion of the Most Responsible Healthcare Practitioner (MRHP).
- Patients with a history of hypertension, cardiovascular disease, previous thrombotic events or dehydration are at increased risk of thrombus formation especially with large doses and rapid infusion rates
- Patients predisposed to acute renal failure or over 65 years of age should have IVIG products administered at a slower rate. Recommended maximum 4 mL/kg/h.
- Patients should be clinically reassessed with each rate change according to protocol.
- **Please call the on call Transfusion Medicine Physician (TMP) if questions arise about dosage, side effects and other concerns as needed.**

The following table is a guideline. Maximum infusion rates at specific intervals should not be exceeded in first-time IVIG recipients. Higher infusion rates may be considered for patients receiving chronic IVIG therapy if tolerated and permitted by the specific product monograph.

	Infusion Rate **Rate calculation check:** **infusion rate (mL/kg/h) x Patient Dosing Weight (kg) x 1 h = infusion rate (mL/h)**			
Patient Dosing Weight* (kg) ***See order set**	**Initial Rate:** **0.5 mL/kg/h**	**Then:** **1 mL/kg/h**	**Then:** **2 mL/kg/h**	**Then:** **4 mL/kg/h** *Note: maximum rate for first-time IVIG infusion*
	Start at (mL/h)	**30 min after start (mL/h)**	**60 min after start (mL/h)**	**90 min after start (mL/h)**
15	**7.5**	**15**	**30**	**60**
20	**10**	**20**	**40**	**80**
25	**12.5**	**25**	**50**	**100**
30	**15**	**30**	**60**	**120**
35	**17.5**	**35**	**70**	**140**
40	**20**	**40**	**80**	**160**
45	**22.5**	**45**	**90**	**180**
50	**25**	**50**	**100**	**200**
55	**27.5**	**55**	**110**	**220**
60	**30**	**60**	**120**	**240**
65	**32.5**	**65**	**130**	**260**
70	**35**	**70**	**140**	**280**
75	**37.5**	**75**	**150**	**300**
80	**40**	**80**	**160**	**320**
85	**42.5**	**85**	**170**	**340**
90	**45**	**90**	**180**	**360**
95	**47.5**	**95**	**190**	**380**
100	**50**	**100**	**200**	**400**
105	**52.5**	**105**	**210**	**400**
110	**55**	**110**	**220**	**400**
115	**57.5**	**115**	**230**	**400**
120+	**60**	**120**	**240**	**400**

Smart Pump line:
'blood IVIG 10% Pilot'
Select DOSE 1 for any first-time IVIG infusion;
Select DOSE 2+ for subsequent IVIG infusions (higher upper infusion rate allowance)