KAISER PERMANENTE®

Immune Globulin (Gammagard S/D) – IVIG –
Infusion Therapy Plan Orders

Name: _____

Kaiser Permanente Member I.D. # _____

Date of Birth _____

Instructions to Provider
Review orders and note any changes. All orders with ☑ will be placed unless otherwise noted. Please fax completed order form to the infusion center where the patient will be receiving treatment (see fax numbers at the end of this protocol). Lab orders are not included on this form – place orders via usual method. Lab monitoring is the responsibility of the ordering physician.

PLEASE NOTE: GAMMAGARD LIQUID is the standard product used for Kaiser Permanente Facilities. Please use order form for GAMMAGARD LIQUID, unless patient specifically needs the GAMMAGARD S/D formulation.

Please complete all of the following:

☐ **Pre-Service Authorization** has been obtained by Kaiser Permanente **Fax:** 1-888-282-2685 **Voice**: 1-800-289-1363

Order Date: _____ **Dosing Weight**: _____ kg Please see guidance below for standard dosing.	**Diagnosis:** ICD-10 code *(REQUIRED):* _____ ICD-10 description_____ _____

Dosing Guidance:

1. Determine/Calculate Boxes A, B, and C.
2. Determine appropriate dosing weight.

A. Actual Body Weight (Act. BW) _____ kg	**B. Ideal Body Weight (IBW) _____ kg**	**C. Adjusted Body Weight (Adj. BW) _____ kg**
Date measured/recorded: _____	Male= 50 + 2.3 (Ht in Inches–60) Female= 45.5 + 2.3 (Ht in Inches-60)	Adjusted BW= Box **B** + 0.4(Box **A**-Box **B**)

If Actual Body Weight < Ideal Body Weight	➡	**Use Actual Body Weight as dosing weight (Box A)**
If Actual Body Weight > 20% above IBW	➡	**Use Adjusted Body Weight as dosing weight (Box C)**
All Other Patients	➡	**Use Ideal Body Weight as dosing weight (Box B)**

General Plan Communication
Special instructions/notes: _____
For Neurology Indications:
- Data is insufficient to recommend an optimal dosing regimen for patients with CIDP, GBS, and/or MG. A dose of 2 grams/kilogram in divided doses over 2 to 5 days, such as 0.4 gram/kilogram/day for 5 days can be considered.

Please verify CORRECT weight is used for dosing.

Provider Information
- Ensure baseline serum creatinine (SCr) and complete blood count (CBC) have been completed within 3 months prior to administration of first dose.
- Infusion rates should not go beyond 3.2 milligram/kilogram/minute for
  - Patients at risk for thrombotic event **or**
  - Patients with risk factors for renal dysfunction (over 65 years old, diabetes, abnormal renal function tests)

Please choose EITHER General Infusion OR Disease Specific Infusion:

☐ **General Infusion Therapy *(See below for disease specific indications)***

Immune globulin-human (GAMMAGARD S/D) IV infusion*
Dose: _____ gram/kg x dosing weight = _____ grams
(Dose will be rounded to the nearest 1 gram.)
Route: Intravenous
Frequency: _____

*Pharmacy: Infuse as 5% solution for initial Gammagard S/D therapy.
Infuse as 10% solution only if patient has no adverse reaction to previous 5% solution Gammagard S/D infusion.

Infusion Rate: Titrate per Kaiser Permanente Nursing Protocol – IV Immune Globulin

Note any changes to above regimen: _____

☐ **Infusion Therapy: Disease Specific**

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), Guillain-Barre Syndrome (GBS), and Myasthenia Gravis (MG)

Induction Infusion

☐ **Immune globulin-human (GAMMAGARD S/D) IV infusion***

Dose: **0.4 gram/kilogram** x dosing weight = _____ grams
(Dose will be rounded to the nearest 1 gram.)
Route: Intravenous
Frequency: **5 (consecutive) days**

*Pharmacy: Infuse as 5% solution for initial Gammagard S/D therapy.
Infuse as 10% solution only if patient has no adverse reaction to previous 5% solution Gammagard S/D infusion.

Infusion Rate: Titrate per Kaiser Permanente Nursing Protocol – IV Immune Globulin

Note any changes to above regimen: _____

Maintenance Infusion

☐ **Immune globulin-human (GAMMAGARD S/D) IV infusion***

Dose: _____ gram/kg x dosing weight = _____ grams
(Dose will be rounded to the nearest 1 gram.)
Route: Intravenous
Frequency: _____

*Pharmacy: Infuse as 5% solution for initial Gammagard S/D therapy.
Infuse as 10% solution only if patient has no adverse reaction to previous 5% solution Gammagard S/D infusion.

Infusion Rate: Titrate per Kaiser Permanente Nursing Protocol – IV Immune Globulin

Note any changes to above regimen: _____

Pre-Meds

☑ acetaminophen (TYLENOL) tablet
Dose: 650 mg *Route:* Oral *Frequency:* Once, 30 minutes prior to IVIG infusion.
May also be given once as needed during infusion for fever, headache, or myalgia to infusion.

☑ cetirizine (ZYRTEC) tablet
Dose: 10 mg *Route:* Oral
Frequency: Once, at least 60 minutes prior to IVIG infusion (if not taken at home).

☐ Other: _____
Dose: _____ *Route:* Oral *Frequency:* Once, 30 minutes prior to IVIG infusion

☐ No routine pre-medications necessary. Above pre-meds may be given if patient has reaction and requires pre-medications for future doses.

IV Line Care

☑ dextrose 5% infusion (D5W) 250 mL
Rate: 30 mL/hr *Route:* Intravenous
Frequency: Run continuously to keep vein open.
Start peripheral IV if no central line.

Infusion Reaction Meds

☑ albuterol (PROVENTIL) nebulizer solution 0.083%
Dose: 2.5 mg *Route:* Nebulization *Frequency:* PRN for shortness of breath/wheezing

☑ diphenhydrAMINE (BENADRYL) injectable
Dose: 25 mg *Route:* Intravenous *Frequency:* Once PRN, may repeat x1 for urticaria, pruritus, shortness of breath. May repeat in 15 minutes if symptoms not resolved.

☑ EPINEPHrine (EpiPen) 0.3 mg/ 0.3mL IM Auto-Injector
Dose: 0.3 mg *Route:* Intramuscular *Frequency:* Once PRN for anaphylaxis. Inject into lateral thigh and hold for 10 seconds. Massage the injected area. Use for patients weighing greater than 27.3 kg (60 lbs). Use amp and 1.5 inch needle for patients with BMI greater than 30. Notify physician if administered.

☑ MethylPREDNISolone Sod Succ (PF) Inj 125 mg (SOLU-Medrol PF).
Dose : 125 mg Route : IV push Frequency: Once PRN for hypersensitivity reaction. Notify MD upon giving medication.

Nursing Orders

- Weight should be recorded at least every 6 months or more frequently as appropriate. Notify physician if weight has changed 10% or greater from baseline.
- If infusion-related reaction, 1) STOP infusion immediately; 2) Increase primary infusion to wide open rate; 3) Administer PRN medications per hypersensitivity protocol; 4) Notify MD.
- Stop infusion and report these signs of adverse effects to provider and/or call the code team immediately: 1) Transfusion-related acute lung injury (TRALI): severe respiratory distress, pulmonary edema, hypoxemia, fever in the presence of normal left ventricular function, sudden development of dyspnea, and hypotension.
- Discontinue IV line when therapy complete and patient stabilized.

References

- GAMMAGARD S/D Prescribing Information Revised 2014.
- Kaiser Permanente Nursing Protocol - IV Immune Globulin (for internal use only)

Kaiser Permanente Infusion Locations

Bellevue Medical Center
11511 NE 10th St, Bellevue, WA 98004
Fax: 425-502-3811 Phone: 425-502-3820

Capitol Hill Medical Center
201 16th Ave E, Seattle WA 98112
Fax: 206-326-3624 Phone: 206-326-3180

Everett Medical Center
2930 Maple St, Everett, WA 98201
Fax: 425-261-1578 Phone: 425-261-1566

Olympia Medical Center
700 Lilly Road N.E., Olympia, WA 98506
Fax: 360-923-7609 Phone: 360-923-7600

Riverfront Medical Center – Spokane
W 322 North River Drive, Spokane, WA 99201
Fax: 509-434-3184 Phone: 509-324-6464

Silverdale Medical Center
10452 Silverdale Way NW, Silverdale, WA 98383
Fax: 360-307-7421 Phone: 360-307-7316

Tacoma Medical Center
209 Martin Luther King Jr Way, Tacoma, WA 98405
Fax: 253-596-3351 Phone: 253-596-3350

Provider Signature: _____ **Date:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____