

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 GAMUNEX-C 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

<b>Order Date:</b> _____  <b>Dosing Weight:</b> _____ kg Please see guidance below for standard dosing.	<b>Diagnosis:</b> ICD-10 code (REQUIRED): _____  ICD-10 description _____ _____
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**Dosing Guidance:**

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

<b>A. Actual Body Weight (Act. BW)</b> _____ kg  Date measured/recorded: _____	<b>B. Ideal Body Weight (IBW)</b> _____ kg  Male= 50 + 2.3 (Ht in Inches-60) Female= 45.5 + 2.3 (Ht in Inches-60)	<b>C. Adjusted Body Weight (Adj. BW)</b> _____ kg  Adjusted BW= Box <b>B</b> + 0.4(Box <b>A</b> -Box <b>B</b> )
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<b>If Actual Body Weight &lt; Ideal Body Weight</b>	➔	<b>Use Actual Body Weight as dosing weight (Box A)</b>
<b>If Actual Body Weight &gt; 20% above IBW</b>	➔	<b>Use Adjusted Body Weight as dosing weight (Box C)</b>
<b>All Other Patients</b>	➔	<b>Use Ideal Body Weight as dosing weight (Box B)</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 (GAMUNX-C) 10% IV infusion**  
 Dose: \_\_\_\_\_ gram/kg x dosing weight = \_\_\_\_\_ grams  
 (Dose will be rounded to the nearest 1 gram.)  
 Route: Intravenous  
 Frequency: \_\_\_\_\_  
 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 (GAMUNEX-C) 10% 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**  
 Infusion Rate: Titrate per [Kaiser Permanente Nursing Protocol – IV Immune Globulin](#)

**Note any changes to above regimen:** \_\_\_\_\_

## Maintenance Infusion

Immune globulin-human (GAMUNEX-C) 10% IV infusion

Dose: \_\_\_\_\_ gram/kg x dosing weight = \_\_\_\_\_ grams

(Dose will be rounded to the nearest 1 gram.)

Route: Intravenous

Frequency: \_\_\_\_\_

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

- [GAMUNEX-C Prescribing Information Revised January 2020.](#)
- [Kaiser Permanente Nursing Protocol - IV Immune Globulin](#) (for internal use only)

## Kaiser Permanente Infusion Locations

### Bellevue Medical Center

11511 NE 10<sup>th</sup> St, Bellevue, WA 98004

Fax: 425-502-3811 Phone: 425-502-3820

### Capitol Hill Medical Center

201 16<sup>th</sup> 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:** \_\_\_\_\_