CHILDREN'S HEALTH

Patient Name: _____

Date of Birth: _____

PHYO
CMC84597-001NS Rev. 1/2021

Intravenous Immunoglobulin (IVIG) (Neurology) Therapy Plan

Baseline Patient Demographic

To be completed by the ordering provider.

☐ NKDA - No Known Drug Allergies Height: _____ cm Weight: _____ kg Body Surface Area: _____ (m^2)

☐ Allergies: _____

Therapy Plan orders extend over time (several visits) including recurring treatment.

Please specify the following regarding the entire course of therapy:

Duration of treatment: _____ weeks _____ months _____ unknown

Treatment should begin: ☐ as soon as possible (within a week) ☐ within the month

****Plans must be reviewed / re-ordered at least annually. ****

ORDERS TO BE COMPLETED FOR EACH THERAPY

ADMIT ORDERS

☑ **Height and weight**
☑ **Vital signs**

HYPOTENSION DEFINED ADMIT

☐ **Nursing communication**

Prior to starting infusion, please determine the patient's threshold for hypotension as defined by the following parameters. This information will be needed in the event of an infusion reaction occurring.
Hypotension is defined as follows:
1 month to 1 year - systolic blood pressure (SBP) less than 70
1 year to 11 years - systolic blood pressure (SBP) less than 70 = (2 x age in years)
11 years to 17 years - systolic blood pressure (SBP) less than 90
OR any age - systolic blood pressure (SBP) drop of more than 30% from baseline.
Baseline systolic blood pressure (SBP) x 0.7 = value below defined as hypotension.

NURSING ORDERS

Please select all appropriate therapy

IV START NURSING ORDERS

☐ **Insert Peripheral IV**
Place PIV if needed or access IVAD if available

☐ **lidocaine 1% BUFFERED (J-TIP LIDOCAINE) injection**
0.2 mL, INTRADERMAL, PRN

☐ when immediate procedure needed
☐ when procedure will take about 1 minute
☐ patient/family preference for procedure

Administration Instructions: NOTE: Do not use this medication in patients with bleeding disorders, platelets ≤ 20,000, or in patients taking anticoagulants, when accessing implanted ports or using a vein that will be utilized for chemotherapy administration, nor for pre-term infants or neonates.

☐ **lidocaine - prilocaine (EMLA) cream**
TOPICAL, PRN

☐ when more than 60 minutes are available before procedure
☐ when procedure will take more than 1 hour
☐ patient/family preference for procedure

Administration Instructions: NOTE: In children < 3 months of age, or < 5 kg in weight, maximum application time is 1 hour.

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NURSING ORDERS

☐ **lidocaine - tetracaine (SYNERA) patch**
TOPICAL, PRN

- ☐ when 20 - 30 minutes are available before procedure
- ☐ when procedure will take more than 1 hour
- ☐ when anticipated pain is less than 5 mm from skin surface
- ☐ patient/family preference for procedure

☐ **lidocaine with transparent dressing 4 % kit**
TOPICAL, PRN

- ☐ when 20 - 30 minutes are available before procedure
- ☐ when procedure will take more than 1 hour
- ☐ patient/family preference for procedure

Select One:

☐ **heparin 10 unit / mL flush**
10 - 50 units, INTRAVENOUS, PRN, IV line flush. Per protocol, heparin should not be used to flush peripheral IVs. This heparin flush should be used with all central lines including IVADs, with the exception of de-accessing the IVAD.

☐ **heparin flush 100 unit / mL flush**
100 - 300 Units, INTRAVENOUS, PRN, IV line flush. Per protocol, heparin should not be used to flush peripheral IVs. For use only when de-accessing IVADs.

☐ **sodium chloride flush 0.9%**
1 - 20 mL, INTRAVENOUS, PRN, IV line flush

☐ **sodium chloride - pres free 0.9% injection**
1 - 30 mL, INTRAVENOUS, PRN, IV line flush

PRE-PROCEDURE LABS

☐ **Blood Urea Nitrogen**
Unit collect

☐ **Creatinine**
Unit collect

PRE-MEDICATIONS

☐ **Acetaminophen pre-medication 30 minutes prior (15 mg / kg, maximum 650 mg) nursing communication**
Administer only one of the acetaminophen orders, suspension or tablets, do not give both.

acetaminophen suspension
15 mg / kg, ORAL, for 1 dose pre-medication, give 30 minutes prior to infusion
Dose: _____

acetaminophen tablet
15 mg / kg ORAL, for 1 dose pre-medication, give 30 minutes prior to infusion
Dose: _____

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PRE-MEDICATIONS, CONTINUED

☐ **Diphenhydramine pre-medication 30 minutes prior (1 mg / kg, maximum 50 mg)**
nursing communication
Administer only one of the diphenhydrAMINE pre-medication orders, liquid, capsule or injection, do not give more than one of the orders as a pre-medication.

diphenhydrAMINE liquid
1 mg / kg, ORAL, for 1 dose pre-medication, give 30 minutes prior to infusion
Dose: _____

diphenhydrAMINE capsule
1 mg / kg ORAL, for 1 dose pre-medication, give 30 minutes prior to infusion
Dose: _____

diphenhydrAMINE injection
1 mg / kg, INTRAVENOUS, 1 dose pre-medication, give 30 minutes prior to infusion
Dose: _____

☐ **Ibuprofen pre-medication 30 minutes prior (10 mg / kg, maximum 600 mg)**
nursing communication
Administer only one of the ibuprofen orders, suspension or tablets, do not give both.

ibuprofen suspension
10 mg / kg, ORAL, for 1 dose pre-medication, give 30 minutes prior to infusion
Dose: _____

ibuprofen tablet
10 mg / kg ORAL, for 1 dose pre-medication, give 30 minutes prior to infusion
Dose: _____

☐ **Ondansetron pre-medication 30 minutes prior (0.1 mg / kg, maximum 4 mg)**
nursing communication
Administer only one of the ondansetron orders, solution or ODT, do not give both.

ondansetron solution
ORAL, PRN, pre-medication, give 30 minutes prior to infusion, for 1 dose
Dose: _____

ondansetron ODT
ORAL, PRN, pre-medication, give 30 minutes prior to infusion, for 1 dose
Dose: _____

NS bolus
sodium chloride 0.9% for fluid bolus
10 mL / kg, Intravenous, Once, PRN, pre-medication, give 30 minutes prior to infusion, Administer over 30 minutes.
Dose: _____

Therapy appointment request

Please select department for the therapy appointment request:

Expires in 365 days

☐ DAL Special Procedures
☐ Plano Infusion Center
☐ DAL Allergy
☐ DAL Transplant
☐ DAL Neurology

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INTRA-PROCEDURE

☑ **Physician communication order**

Gamunex is the preferred CHST product. Please select the appropriate Gamunex section based on the following dosing:
Total dose = 2 gm / kg divided over 2 to 5 days (1 gm / kg x 2 days, 0.7 gm / kg x 3 days, 0.5 gm / kg x 4 days, or 0.4 gm / kg x 5 days).
Please enter the dose of IVIG as grams to facilitate prior authorization requirements. If Gammagard is needed, select the appropriate order with the same dosing above.

☑ Vital signs Baseline blood pressure pulse, respirations and temperature prior to starting of IVIG infusion, observe frequently, every 15 - 30 minutes, upon initiation of IVIG infusion for signs of symptoms and / or complaints of infusion related reactions. Monitor every 15 - 30 minutes until maximum infusion rate is reached. Continue vital signs hourly after maximum rate is reached. If an adverse effect occurs, slow the infusion rate or temporarily interrupt the infusion.

☑ **Nursing communication**

IVIG administration rate if using a 10 % solution:
** Consider reduced infusion rate if patient is at risk for renal insufficiency, thromboembolic events, volume overload, and / or utilizing 10% solution for initial dose INFUSE OVER _____ HOURS** (see policy for reduced rate)

Initial Infusion Rate (Reduced Rate) = (0.05 g /kg / hour) 0.5mL / kg / hour	After 15 - 30 minutes at previous rate
(0.025 g / kg / hour) 0.25 mL / kg / hour)	(0.1 g / kg / hour) 1 mL / kg / hour
(0.05 g / kg / hour) 0.5 mL / kg / hour)	(0.2 g / kg / hour) 2 mL / kg / hour
(0.1 g / kg / hour) 1 mL / kg / hour)	(0.4 g / kg / hour) 4 mL / kg / hour
(**Maximum Initial Infusion / Reduced Rate (0.2 g / kg / hour) 2 mL / kg / hour)	

Gamunex is the preferred CHST product. Please select Gammagard only if clinically warranted. Dose of IVIG typically begins at 400 mg/kg. Please enter the dose of IVIG in 'gm' to facilitate Prior Authorization requirements.Please select the appropriate product (Gamunex or Gammagard) and number of days over which the total infusion should be administered (2 - 5 days):

☐ **IVIG - GAMUNEX - C (1 gm / kg x 2 days):**

immune globulin 10% (GAMUNEX - C) 1 gram / 10 mL (10%) injection **Day 1**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" hyperlink for administration directions.
Dose: _____

immune globulin 10% (GAMUNEX - C) 1 gram / 10 mL (10%) injection **Day 2**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" hyperlink for administration directions.
Dose: _____

☐ **IVIG - GAMUNEX - C (0.7 gm / kg x 3 days) :**

immune globulin 10% (GAMUNEX - C) 1 gram / 10 mL (10%) injection **Day 1**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

immune globulin 10% (GAMUNEX - C) 1 gram / 10 mL (10%) injection **Day 2**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

immune globulin 10% (GAMUNEX - C) 1 gram / 10 mL (10%) injection **Day 3**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

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ORDERS TO BE COMPLETED FOR EACH THERAPY

INTRA-PROCEDURE, CONTINUED

☐ **IVIG - GAMUNEX - C (0.5 gm / kg x 4 days):**

immune globulin 10% (GAMUNEX - C) 1 gram / 10 mL (10%) injection **Day 1**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

immune globulin 10% (GAMUNEX - C) 1 gram / 10 mL (10%) injection **Day 2**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

immune globulin 10% (GAMUNEX - C) 1 gram / 10 mL (10%) injection **Day 3**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

immune globulin 10% (GAMUNEX - C) 1 gram / 10 mL (10%) injection **Day 4**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

☐ **IVIG - GAMUNEX - C (0.4 gm / kg x 5 days):**

immune globulin 10% (GAMUNEX - C) 1 gram / 10 mL (10%) injection **Day 1**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

immune globulin 10% (GAMUNEX - C) 1 gram / 10 mL (10%) injection **Day 2**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

immune globulin 10% (GAMUNEX - C) 1 gram / 10 mL (10%) injection **Day 3**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

immune globulin 10% (GAMUNEX - C) 1 gram / 10 mL (10%) injection **Day 4**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

immune globulin 10% (GAMUNEX - C) 1 gram / 10 mL (10%) injection **Day 5**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

INTRAVENOUS IMMUNOGLOBULIN (IVIG) - GAMMAGARD

Physician communication order
Please select the appropriate product (GAMUNEX or GAMMAGARD) and number of days over which the total infusion should be administered (2 - 5 days)': If GAMMAGARD is needed select the appropriate section below. Total dose = 2 gm / kg / divided over 2 to 5 days. (1 gm / kg x 2 days,0.7 gm / kg x3 days, 0.5 gm / kg x 4 days or 0.4 gm / kg x 5 days) Please enter the dose of IVIG in gram to facilitate prior authorization requirements

☐ **IVIG - GAMMAGARD (1 gm / kg x 2 days):**

immune globulin 10% (GAMMAGARD) 10% injection **Day 1**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

immune globulin 10% (GAMMAGARD) 10% injection **Day 2**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

Key: cm = centimeter; gm = gram; IV = intravenous; IVAD = implantable venous access device; IVIG = intravenous immunoglobulin; kg = kilogram; m^2 = square meters; mg = milligram; mL = milliliter; mL / hr = milliliters per hour; mOsm / L = millisomole per liter; NKDA = No Known Drug Allergies; NS = normal saline solution (0.9% sodium chloride solution); pH = hydrogen ion concentration; PIV = peripheral intravenous; PRN = as needed; PVC = peripheral venous catheter

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ORDERS TO BE COMPLETED FOR EACH THERAPY

POST - PROCEDURE, CONTINUED

☐ **IVIG - GAMMAGARD 0.7 gm / kg x3 days:**

immune globulin 10% (GAMMAGARD) 10% injection **Day 1**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

immune globulin 10% (GAMMAGARD) 10% injection **Day 2**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

immune globulin 10% (GAMMAGARD) 10% injection **Day 3**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

☐ **IVIG - GAMMAGARD (0.5 gm / kg x 4 days) :**

immune globulin 10% (GAMMAGARD) 10% injection **Day 1**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

immune globulin 10% (GAMMAGARD) 10% injection **Day 2**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

immune globulin 10% (GAMMAGARD) 10% injection **Day 3**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

immune globulin 10% (GAMMAGARD) 10% injection **Day 4**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

☐ **IVIG - GAMMAGARD (0.4 gm / kg x 5 days):**

immune globulin 10% (GAMMAGARD) 10% injection **Day 1**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

immune globulin 10% (GAMMAGARD) 10% injection **Day 2**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

immune globulin 10% (GAMMAGARD) 10% injection **Day 3**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

immune globulin 10% (GAMMAGARD) 10% injection **Day 4**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

immune globulin 10% (GAMMAGARD) 10% injection **Day 5**
INTRAVENOUS, ONCE, see "IVIG Administration Policy" for administration directions.
Dose: _____

Key: cm = centimeter; gm = gram; IV = intravenous; IVAD = implantable venous access device; IVIG = intravenous immunoglobulin; kg = kilogram; m^2 = square meters; mg = milligram; mL = milliliter; mL / hr = milliliters per hour; mOsm / L = millisomole per liter; NKDA = No Known Drug Allergies; pH = hydrogen ion concentration; PIV = peripheral intravenous; PRN = as needed; PVC = peripheral venous catheter

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EMERGENCY MEDICATIONS

☑ **Nursing communication**

1. Hives or cutaneous reaction only – no other system involvement: **PATIENT IS HAVING A DRUG REACTION**
   - **a.** Stop the infusion
   - **b.** Give diphenhydramine as ordered
   - **c.** Check vitals including blood pressure every 5 minutes until further orders from provider.
   - **d.** Connect patient up to monitor (cardiac / apnea, blood pressure and oxygen saturation) if not already on one
   - **e.** Notify provider for further orders

2. Hives or cutaneous reaction plus one other system, i.e. abdominal cramping, vomiting, hypotension, altered mental status, respiratory distress, mouth / tongue swelling: **PATIENT IS HAVING ANAPHYLAXIS**

☐
- **a.** Stop the infusion
- **b.** Call code – do not wait to give epinephrine
- **c.** Give epinephrine as ordered
- **d.** Notify provider
- **e.** Check vitals including blood pressure (BP) every 5 minutes until the code team arrives.
- **f.** Connect patient up to monitor (cardiac / apnea, blood pressure and oxygen saturation), if not already on one.
- **g.** Give diphenhydramine once as needed for hives
- **h.** May repeat epinephrine every 5 minutes x 2 doses for persistent hypotension and respiratory distress with desaturation until code team arrives.
- **i.** May give albuterol as ordered for wheezing with oxygen saturation stable while waiting for code team – continue to monitor oxygen saturation.

Hypotension is defined as follows:
1 month to 1 year – systolic blood pressure (SBP) less than 70
1 year to 11 years – systolic blood pressure (SBP) less than 70 + (2 x age in years)
11 years to 17 years – systolic blood pressure (SBP) less than 90
OR any age – systolic blood pressure (SBP) drop more than 30% from baseline.
Baseline systolic blood pressure (SBP) x 0.7 = value below defined as hypotension.

☑ **EPINEPHrine Injection**
(AMPULE / EPI - PEN JR. / EPI - PEN)
0.01 mg / kg, INTRAMUSCULAR, EVERY 5 MINUTES PRN, for anaphylaxis and may be repeated for persistent hypotension and respiratory distress with desaturation until the code team arrives, For 3 doses Use caution with PIV administration. This solution has a pH < 5, or a pH > 9, or an osmolality > 600 mOsm / L.
Dose: _____

☑ **Cardio / respiratorymonitoring rationale for monitoring:**
high risk patient (please specify risk)
(Patient receiving infusion with potential infusion reactions);
heart rate, respiratory rate, oxygen saturation
Rationale for Monitoring: High risk patient (please specify risk)
Parameters: heart rate, respiratory rate, oxygen saturation
Alarm limits: preset to age specified limits

☑ **diphenhydrAMINE injection 1 mg / kg**
1 mg / kg, INTRAVENOUS, ONCE PRN, for hives or cutaneous reaction, for 1 dose maximum dose = 50 mg per dose, 300 mg per day.
Dose: _____

☑ **albuterol for aerosol 0.25 mg / kg**
0.25 mg / kg., INHALATION, ONCE PRN, for wheezing, but oxygen saturations stable while waiting for code team, continue to monitor oxygen saturations for 1 dose
Dose: _____

POST - PROCEDURE

☑ **Nursing communication**

Flush PIV or IVAD with 10 - 20 mL 0.9% sodium chloride at the completion of the infusion. Flush IVAD with saline and heparin flush per protocol prior to de - accessing IVAD.

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POST - PROCEDURE

☑ **sodium chloride flush 0.9%**

10 - 20 mL, INTRAVENOUS, PRN, IV line flush

Dose: _____

Signature of Provider	(circle one): MD DO Credentials	Date	Time

Printed Name of Provider

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