



Change order details by crossing out unwanted information and writing in desired details/instructions.
Place a line through the **x** to remove the pre-checked option.

IMMUNE GLOBULIN (IVIG) INFUSION PLAN [11500854] Columbia Network Infusion Centers

Select Location: ☐ Southwest/Vancouver ☐ St John/Longview Start Date: _____

Diagnosis/Indication: _____

ICD-10 Code(s): _____ Authorization Number: _____

Patient Vitals: Height _____ Weight _____

Provider Communication Orders

To reduce delays in treatment and phone calls to your office, you may participate in the PeaceHealth formulary process by selecting this option. A clinic pharmacist will adjust orders according to PeaceHealth site approved policies and procedures.

- ☒ ***I agree to utilize the PeaceHealth policies & procedures that have been reviewed by the Pharmacy & Therapeutics Committee and authorized by the Medical Executive Committee of PeaceHealth. This agreement will be issued for the duration of active orders contained within this treatment plan.***

Labs

Interval

- | | |
|---|-----------------|
| <input type="radio"/> BUN | Frequency _____ |
| <input type="radio"/> CBC W/ Automated Differential | Frequency _____ |
| <input type="radio"/> DAT, Polyspecific | Frequency _____ |
| <input type="radio"/> Immunoglobulin G, Total | Frequency _____ |
| <input type="radio"/> Creatinine | Frequency _____ |

Pre-Medications

Interval

- | | | |
|--|-------------|-------------|
| <input checked="" type="checkbox"/> acetaminophen (TYLENOL) tablet 650 mg | Every Visit | Route: Oral |
| <input checked="" type="checkbox"/> diphenhydramine (BENADRYL) capsule 25 mg | Every Visit | Route: Oral |
| <input type="radio"/> dexamethasone (DECADRON) IV 10 mg | Every Visit | Route: IV |

Supportive Care

Interval

- | | |
|---|-----------------|
| <input type="radio"/> Immune Globulin (PRIVIGEN) 400 mg/kg IV Once every month for _____ months | |
| <input type="radio"/> Immune Globulin (PRIVIGEN) 400 mg/kg IV Every day x 5 days | Frequency _____ |
| <input type="radio"/> Immune Globulin (PRIVIGEN) 1000 mg/kg IV Every day x 2 days | Frequency _____ |
| <input type="radio"/> Immune Globulin (PRIVIGEN): Dose _____ | Frequency _____ |

If Insurance requires a product other than Privigen, please call us directly at 360-514-2005 to discuss.

Provider Signature

Date

Time

Provider's Printed Name: _____

Place Patient Label Here

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IMMUNE GLOBULIN (IVIG) INFUSION PLAN

Vascular Access (single select)		Interval
<input type="radio"/> IV	<ul style="list-style-type: none"> - Insert peripheral IV - sodium chloride (NS) flush 10 mL <i>10 mL As Needed for Line Care</i> 	Every Visit
<input type="radio"/> Central line (non-PICC)	<ul style="list-style-type: none"> - Access vascular device and confirm patency - Initiate Central line (non-PICC) maintenance protocol - sodium chloride (NS) flush 10 mL <i>10 mL As Needed for Line Care prior to medication administration PRN</i> - sodium chloride (NS) flush 10 mL <i>10 mL As Needed for Line Care post medication administration PRN</i> - sodium chloride (NS) flush 20 mL <i>20 mL As Needed for Line Care post lab draw PRN</i> - sodium chloride (NS) flush 10 mL <i>10 mL for Line Care at discharge and de-access every visit</i> - heparin 100 units/mL 5 mL <i>5 mL for de-access PRN</i> - alteplase (CATHFLO) injection 2 mg <i>Other, Starting when released, For 2 dose, PRN, For clearing central line catheter. Add 2.2 mL sterile water for injection to vial; let the vial stand undisturbed to allow large bubbles to dissipate. Mix gently swirling until completely dissolved (complete dissolution should occur within 3 minutes); do not shake. Final concentration: 1 mg/mL. Retain in catheter for 30 minutes to 2 hours, instill a 2nd dose if occluded</i> 	Every Visit
<input type="radio"/> PICC line	<ul style="list-style-type: none"> - Access vascular device and confirm patency - Initiate PICC maintenance protocol - Nursing Communication <i>Change PICC line dressing weekly and PRN</i> - sodium chloride (NS) flush 10 mL <i>10 mL As Needed for Line Care prior to medication administration PRN</i> - sodium chloride (NS) flush 10 mL <i>10 mL As Needed for Line Care post medication administration PRN</i> - sodium chloride (NS) flush 20 mL <i>20 mL As Needed for Line Care post lab draw PRN</i> - alteplase (CATHFLO) injection 2 mg <i>Other, Starting when released, For 2 dose, PRN, For clearing central line catheter. Add 2.2 mL sterile water for injection to vial; let the vial stand undisturbed to allow large bubbles to dissipate. Mix gently swirling until completely dissolved (complete dissolution should occur within 3 minutes); do not shake. Final concentration: 1 mg/mL. Retain in catheter for 30 minutes to 2 hours, instill a 2nd dose if occluded</i> 	Every Visit

PRN Medications	Interval	
<input type="radio"/> sodium chloride (NS) flush 10 mL <i>10 mL As Needed for Line Care</i>	PRN	Route: IV
<input type="radio"/> sodium chloride 0.9 % bolus 500 mL <i>500 mL Once for Line Care, Starting when released, For 1 dose, Run at TKO (25ml/hr)</i>	PRN	Route: IV

Provider Signature

Date

Time

Provider's Printed Name:

Place Patient Label Here

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IMMUNE GLOBULIN (IVIG) INFUSION PLAN

Emergency Medications**Interval**

- | | | | |
|----------|--|-----|----------------------|
| X | diphenhydrAMINE (BENADRYL) injection 25-50 mg
<i>25-50 mg Once As Needed IV, For mild to moderate drug reactions (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (\geq 20 points in SBP), nausea, urticaria, chills, pruritis). Administer 50 mg IV if patient has NOT had diphenhydramine within 2 hours of reaction. Administer 25 mg IV if patient has had diphenhydramine within 2 hours of reaction, if reaction doesn't resolve in 3 minutes may repeat 25 mg IV dose for a total of 50 mg, and contact provider.</i> | PRN | Route: IV |
| X | albuterol 90 mcg/actuation inhaler 2 puff
<i>2 puff Once As Needed Inhalation, Wheezing, Shortness of Breath, wheezing, shortness of breath associated with infusion reaction and notify provider. Administer with a spacer if available.</i> | PRN | Route: Inhalation |
| X | methyIPREDNISolone sodium succinate (Solu-MEDROL) Injection 125 mg
<i>125 mg Once As Needed IV, For shortness of breath for continued symptoms of mild to moderate drug reactions (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (\geq 20 points in SBP), nausea, urticaria, chills, pruritis) that worsen or persist 5 minutes after administration of diphenhydramine (Benadryl), and contact provider.</i> | PRN | Route: IV |
| X | EPINEPHrine (ADRENALIN) injection for Allergic Reaction 0.5 mg
<i>0.5 mg Once As Needed Intramuscular, For severe drug reaction (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort plus blood pressure changes (\geq 40 points in SBP), shortness of breath with wheezing and O2Sat <90%), and contact provider.</i> | PRN | Route: Intramuscular |

Provider Signature**Date****Time****Provider's Printed Name:**

Place Patient Label Here

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IMMUNE GLOBULIN (IVIG) INFUSION PLAN