1015 25th Street Building, Upper Level
Anacortes, WA, 98221

Phone: 360.299.4200
Fax: 360.299.4237

PROVIDER ORDER FORM

IV Immune Globulin (Privigen) Infusions

- Please complete form and fax with latest clinical documentation to 360.299.4237

Patient Name (First, Middle, Last): ____ D.O.B. ________________

Height: _____ ☐ cm ☐ in Weight:_____ ☐ kg ☐ lbs Allergies: ____________________________________

Diagnosis: ______________________________________ ICD-10 Code: ______________________________

Pre-auth Done? ☐ Not required ☐ Yes Authorization #: ___________ Authorization Dates: ______________

Pre-Meds/Labs:

Acetaminophen: ☐ 650 mg PO ***or*** ☐ 975 mg PO x 1 30 min before infusion. Patient may decline.

Diphenhydramine: ☐ 25 mg PO ***or*** ☐ 50 mg PO x1 30 min before infusion. Patient may decline.

Other: Labs/Pre-meds____

____

Medication Orders:

☐ Loading dose: **Privigen 10%** (J1459) _________ gm/kg (________ gm) IV x 1 dose

☐ Maintenance dose: **Privigen 10%** _______gm/kg (_______ gm) for ______day(s) every ________week(s)

- ☐ Use Actual body weight
- ☐ Use Ideal body weight
- ☐ Use Adjusted body weight (if BMI ≥ 30 kg/m^2)
  - Round dose to nearest 5 gm vial
  - May infuse +/- 4 days for patient scheduling issues.
  - Privigen infusion rate will be titrated per Island Health Policy.

☐ In case of infusion reaction, orders will be carried out per Island Health Policy unless crossed out.

- Stop infusion, obtain VS and assessment, call Provider.*
- NS 0.9% 1000 mL/hour IV for blood pressure < 100/60.
- O2 per nasal cannula to maintain saturation >92%.
- Diphenhydramine 25 mg IV x1 if patient was premedicated with 25 mg within 2 hours of reaction, otherwise 50 mg IV x1.
- Methylprednisolone succ. 125 mg IV x1.
- Epinephrine 0.3 mg IM x1 for severe reaction (may repeat in 3–5 minutes x1 for continued severe symptoms).

PROVIDER SIGNATURE	DATE
PRINT PROVIDER NAME	*PROVIDER EMERGENCY PHONE #

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