HEADWATERS Health Care Centre

Clear Form

Patient Label

ALLERGIES:_____

☐ No Known Allergies

Outpatient Administration of Immunoglobulins (IVIG) Order Set

ACTION

Fill in the required blanks. Open Box ☐ indicates optional order, activated when checked ☒.
Checked Box ☒ indicates mandatory order unless crossed out. To delete order, draw line through and initial. Orders not checked will not be implemented. Signature, date and time is **REQUIRED**

☐ MOHLTC IVIG or Immune Globulin Screening Pilot (IGSP) (Neurology indications) Request Form completed and faxed

Consent:

☐ I, the prescriber, have obtained written consent

Diagnosis: (indicate reason for infusion)

☐ Guillain-Barré Syndrome
☐ Idiopathic Thrombocytopenia Purpura (ITP)
☐ Myasthenia Gravis
☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
☐ Other: _____

Vitals/Monitoring

Vitals

☒ Baseline weight
☒ Temperature, Heart Rate, Respiration Rate, Blood Pressure, Oxygen Saturation (SpO2)
☒ Once infusion begun, monitor vital signs as needed and post transfusion

Monitoring

☒ Monitor patient for infusion rection (wheezing, chills, rash, itching, flushing, CNS behaviour changes) most likely to occur in the first 15 minutes of infusion.
☒ If reaction occurs, stop infusion and notify Physician immediately
  ☒ Observe urine for hematuria
  ☒ Urine R+M if hematuria is observed

Lab Investigations

Pre-transfusion Blood Work

☐ Additional Labs: _____

Practitioner's Signature _____ Printed Name_____

Date _____Time_____ (24 hrs)

HHCC-2144 2026/09
H.IVIGOS

Please fax this order set to Ambulatory Care Bookings – (519) 941 - 6022

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Premedication

Administer 30 minutes prior to IVIG

☐ Acetaminophen 650 mg PO
☐ DiphenhydrAMINE 25 mg PO
☐ DiphenhydrAMINE 25 mg IV
☐ Hydrocortisone sodium succinate 100 mg IV
☐ Other: _____

IV Immune Globulin (IVIG)

Dose: Dose calculator to be used for all patients and is located on the MOHLTC IVIG Request Form

Induction dose (IV):

☐ Immunoglobulin _____ g/kg = _____ g total dose; _____ g per day x _____ days

Maintenance dose (IV):

☐ Immunoglobulin _____ g/kg (1-2 g/kg) = _____ g total dose;_____ g per day x _____ days, q _____ weeks
☐ Immunoglobulin _____ g IV x 1 dose (2 g/kg)

THEN
Infuse at:
☐ Standard Rate:
- ☒ 100 mL/hr x 15 min, if tolerated THEN
- ☒ 200 mL/hr x 15 min, if tolerated THEN
- ☒ 300 mL/hr x 15 min, if tolerated THEN
- ☒ 400 mL/hr until complete

☐ Custom Rate:
- _____ mg/kg/min x 15 min, if tolerated THEN
- _____ mg/kg/min x 30 min, if tolerated THEN
- _____ mg/kg/min x 30 min, if tolerated THEN
- _____ mg/kg/min until complete

Practitioner's Signature _____ Printed Name_____

Date _____Time_____ (24 hrs)

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Infusion Reaction Management

☒ Acetaminophen 325 - 650 mg PO PRN q 4 hours for pain, fever or chills (Max 4,000 mg in 24 hours)
☒ Salbutamol MDI 100 mcg/puff – 2 puffs inhaled q 4 hours PRN via aero chamber PRN for dyspnea or wheezing
☒ DimenhyDRINATE 25 – 50 mg PO/IV PRN q 4 hours for nausea, vomiting

For itching, urticaria, pruritus, hives:

☐ Cetirizine 10 mg PO x 1 dose for itching, urticaria, pruritus, hives **OR**
☐ DiphenhrydrAMINE 50 mg PO PRN q 4 hours for itching, urticaria, pruritus, hives **OR**
☐ DiphenhrydrAMINE 50 mg IV PRN q 4 hours for itching, urticaria, pruritus, hives

☐ Other: _____

☒ **Mild hypersensitivity reaction (Fishbone reaction):** itching, flushing, urticaria, sensation of heat, slight chest tightness, hypertension, back/joint pains

- ☒ Stop IVIG infusion for 15 minutes or more
- ☒ Monitor BP, RR, SpO2 x 1 and PRN until stable
- ☒ When symptoms resolve, restart IV IVIG infusion at reduced rate of 50% and if tolerating well, complete infusion and observe patient for 60 minutes.
- ☒ If symptoms reoccur, stop IV IVIG infusion and inform MD.

☒ **Anaphylaxis:** If patient experiences persistent hypotension (i.e. SBP drop of 30 mmHg from baseline or SBP less than 90mmHg) or angioedema, or involvement of 2 more organ systems (Skin: urticaria, non-airway angioedema; CV: hypotension, chest pain; Respiratory: stridor, bronchospasm, shortness of breath; GI: vomiting, abdominal pain) while receiving the infusion

- ☒ Stop IVIG infusion immediately
- ☒ Notify MRP **STAT**
- ☒ Keep IV line open with 0.9% NaCl at 30 ml/hr
- ☒ Repeat Temperature, Heart Rate, Respiration Rate, Blood Pressure, Oxygen Saturation (SpO2) x1 and PRN until stable
- ☐ Oxygen via mask/nasal prongs 2 – 5 L/minute PRN for SOB or decreased O2 saturation (below 90% if lower than baseline)
- ☒ EPINEPHrine 0.5 mg IM STAT mid-anterolateral thigh x 1 dose (usual dose 0.01 mg/kg)
- ☒ If anaphylaxis not resolved, repeat IM EPINEPHrine in 5 minutes x 1 dose
- ☐ Hydrocortisone Sodium Succinate 100 mg IV PRN x 1

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