406 ARTHRITIS CLINIC
Get back to your 406 life!

| INFUSION SUITE | | IVIG INFUSION ORDERS | |
|---|---|---|---|
| 406 Arthritis Clinic LLC | | Phone: 406-345-0211 | Fax: 747-205-0742 |
| 2409 Arnold Ln Ste 9 Billings, MT 59102 | | | |
| **PATIENT INFORMATION - Include Patient Demographics and Insurance Cards** | | | |
| **Name:** | | **DOB:** | |
| | **MEDICAL INFORMATION** | | |
| **ICD10:** | | **Patient Height:** | |
| **Patient Weight (kg):** | | **Allergies:** | |
| *Weigh patient prior to each infusion | | | |
| | **REQUIRED TESTING** | | |
| ☐ **IgA antibodies:**_____ | ☐ **BUN/Creatinine:**_____ | ***IgA required prior to initiation** | |
| **Additonal labs:** | | | |
| ☐ **Insert IV** | ☐ **Access Port/PICC** | | |
| | **PREMEDICATIONS 30 minutes prior to starting** | | |
| ☐ **Acetaminophen:** | ☐ 325mg PO X1 ☐ 500mg PO X1 ☐ 650mg PO X1 | | |
| ☐ **Diphenhydramine:** | ☐ 25mg IVP X1 ☐ 25mg PO X1 ☐ 50mg IVP X1 ☐ 50mg PO X1 | | |
| ☐ **Solumedrol:** | ☐ 40mg IV X1 ☐ 100mg IV X1 ☐ 125mg IV X1 | | |
| ☐ **Antihistamine:** | ☐ Cetirizine 10mg PO X1 ☐ Loratadine 10mg PO X1 | | |
| ☐ **Additional PRN:** | | | |
| | **OCTAGAM ORDERS** | | |
| ☐ Octagam Loading: _____ g/kg total dose over _____ day(s) **OR** _____g per day x _____ day(s) (_____ total grams) | | | |
| ☐ Subsequent: ___g/kg daily X __ days for a total of: ____g **OR** ____g per day x __ day(s) every ____ weeks for a total of ___ grams) | | | |
| | **GAMUNEX-C ORDERS** | | |
| ☐ Gamunex-C Loading: _____ g/kg total dose over _____ day(s) **OR** _____g per day x _____ day(s) (_____ total grams) | | | |
| ☐ Subsequent: ___g/kg daily X __ days for a total of: ____g **OR** ____g per day x __ day(s) every ____ weeks for a total of ___ grams) | | | |
| | **GAMMAKED ORDERS** | | |
| ☐ Gammaked Loading: _____ g/kg total dose over _____ day(s) **OR** _____g per day x _____ day(s) (_____ total grams) | | | |
| ☐ Subsequent: ___g/kg daily X __ days for a total of: ____g **OR** ____g per day x __ day(s) every ____ weeks for a total of ___ grams) | | | |
| | **BIVIGAM ORDERS** | | |
| ☐ Bivigam Loading: _____ g/kg total dose over _____ day(s) **OR** _____g per day x _____ day(s) (_____ total grams) | | | |
| ☐ Subsequent: ___g/kg daily X __ days for a total of: ____g **OR** ____g per day x __ day(s) every ____ weeks for a total of ___ grams) | | | |
| | **PRIVIGEN ORDERS** | | |
| ☐ Privigen Loading: _____ g/kg total dose over _____ day(s) **OR** _____g per day x _____ day(s) (_____ total grams) | | | |
| ☐ Subsequent: ___g/kg daily X __ days for a total of: ____g **OR** ____g per day x __ day(s) every ____ weeks for a total of ___ grams) | | | |
| **Other:**_____ | | | |
| ☐ _____ g/kg total dose over _____ day(s) **OR** _____g per day x _____ day(s) (_____ total grams) | | | |
| ☐ Subsequent: ___g/kg daily X __ days for a total of: ____g **OR** ____g per day x __ day(s) every ____ weeks for a total of ___ grams) | | | |
| | **POST INFUSION** | | |
| ☐ Flush IV line with NS. D/C IV. | | ☐ May keep IV/Port for successive treatments | |
| ☐ Flush port with 5-10mL 0.9% NS. Lock port with Heparin 10u/mL IVP (based of size port). De-access port. | | | |
| ☐ Discharge home | | | |
| **Referring Provider Printed:** | | | |
| **Referring Provider Signature:** | | **Date:** | |
| **Referring Provider Phone:** | | **Referring Provider Fax:** | |
| **406 Provider Printed:** | | | |
| **406 Provider Signature:** | | **Date:** | |

***Credentials must be included***

**Infusion Directions:**

- Remove vial and allow to come to room temp before administration
- Hang vials from smallest vial to largest vial (least quantity to largest quantity)
- Discard and document any drug waste
- Infuse per PI/titration table

**Nusing Considerations:**

• IgA-deficient patients with antibodies against IgA are at greater risk of developing severe hypersensitivity and anaphylaxis
• Monitor glucose levels in diabetic patients with a glucose-specific method only.