

 Saskatchewan Health Authority	Standard #:	
	Title:	Transfusion Medicine Laboratory (TML) Screening of Inpatient and Urgent Outpatient ADULT Intravenous Immune Globulin (IVIG) Order Set
	Role performing Activity:	Medical Laboratory Technologists (MLTs)
WORK STANDARD	Location: SHA	Department/Unit: Transfusion Medicine
	Document Owner:	Date Prepared: 03-Jan-2025
	Last Revision: 26-Feb-2025	Date Approved: Enter a date
	Related Policies/Documentation: <ul style="list-style-type: none"> - SHA CS-OS- 1910 Adult Intravenous Immune Globulin – (IVIG) Order Set - Criteria for the Clinical Use of Immune Globulin 2nd Edition - Inpatient and Urgent Outpatient Adult IVIG POS Process Map - Frequently Asked Questions - TML 	

Work Standard Summary:

Essential Tasks:	
<p>1. Receive ADULT Intravenous Immune Globulin (IVIG) Order Set.</p>	<ul style="list-style-type: none"> • Physicians must complete the ADULT Intravenous Immune Globulin (IVIG) Order Set. • All inpatient and urgent outpatient order sets are to be submitted to the local Transfusion Medicine Lab (TML) for screening against the <i>Criteria or the Clinical Use of Immune Globulin 2nd Edition (February 2022)</i>. <ul style="list-style-type: none"> ○ A non-urgent inpatient order set is defined as maintenance IVIG orders not starting immediately. ○ An urgent outpatient order set is defined as IVIG request to be issued within 24 hours. • If TML receives a non-urgent outpatient ADULT Order Set please fax to the IG Stewardship Program at (306) 766-3509. <p><i>Note: The ADULT Intravenous Immune Globulin (IVIG) Order Set must be completed correctly for IVIG administration. If an outdated order set is used, guide the prescribing physician to use the approved order set.</i></p>
<p>2. Identify Vital Information</p>	<ul style="list-style-type: none"> • Confirm the patient’s full name, HSN and DOB are on the top right corner of all three pages of the order set. • Confirm the type of product (e.g. 10% IVIG or 5% IVIG) matches across all 3 pages: <div style="border: 2px solid black; padding: 10px; text-align: center; margin: 10px 0;"> <p>ADULT Intravenous Immune Globulin (IVIG) Order Set</p> <p><input type="checkbox"/> 10% IVIG <input type="checkbox"/> 5% IVIG</p> </div> <p><i>Note: Transfusion Medicine Physician approval is required for all 5% IVIG requests.</i></p> <ul style="list-style-type: none"> • Verify that all three pages are signed by the prescribing physician.

Essential Tasks:																															
	<p><i>Note: If the order set is incomplete contact the ordering patient care unit to complete the missing information.</i></p>																														
3. Lab Investigations	<ul style="list-style-type: none"> • Check for an ABO group. Historical ABO result is acceptable. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="10" style="background-color: #cccccc;">3. Lab Investigations To Be Completed Prior to Initial Treatment</td> </tr> <tr> <td colspan="10" style="font-size: small;"><i>Prescriber to provide lab requisition for outpatient lab testing to patient</i></td> </tr> <tr> <td colspan="10"> <input checked="" type="checkbox"/> ABO Group/Rh – must be completed prior to initial treatment. provide result if known </td> </tr> </table> <ul style="list-style-type: none"> • Provide result if available and initial them. If no ABO found, note that it will need to be drawn before the IVIG infusion and initial the record. 	3. Lab Investigations To Be Completed Prior to Initial Treatment										<i>Prescriber to provide lab requisition for outpatient lab testing to patient</i>										<input checked="" type="checkbox"/> ABO Group/Rh – must be completed prior to initial treatment. provide result if known									
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<input checked="" type="checkbox"/> ABO Group/Rh – must be completed prior to initial treatment. provide result if known																															
4. IVIG Order	<p><i>Note:</i></p> <ul style="list-style-type: none"> • Contact TMP on call by calling switchboard at Royal University Hospital in Saskatoon at 306-655-1000 and asking for the Transfusion Medicine Physician on call. • If an MLT is not available at the site to complete the screening, please contact the IG Stewardship Program Nurse Navigator during office hours (Monday to Friday 08:00-16:30, excluding statutory holidays). If Nurse Navigator is not available, please contact the TMP on call. <p>Step 1: Check the patient’s history of receiving IVIG.</p> <ul style="list-style-type: none"> • Search for the patient’s IVIG history using the LIS and/or eHealth Viewer. <ul style="list-style-type: none"> ○ Confirm type of IVIG provided in past (10% IVIG or 5% IVIG) is the same selected on the current order set. ○ Review for any IVIG Brand Specification notes. <p><i>Note: For all orders, if the patient has received IVIG within the past 30 days, consult the TMP on call to determine the need for the new order set.</i></p> <p>Step 2: Confirm the <i>Diagnosis/Indication</i> is an approved indication.</p> <ul style="list-style-type: none"> • Use the Criteria for the Clinical Use of Immune Globulin (ctrl + f search for key words). • If the indication is green (IVIG recommended) OR yellow (IVIG possibly recommended), continue screening. • If the indication is red (IVIG not recommended), contact the TMP on call for guidance. <p><i>Note: For clarification of the <i>Diagnosis/Indication</i> if not found within the Criteria document reach out to TMP on call.</i></p>																														
5. Adjusted Body Weight (ABW) option A or B.	<p>Adjusted Body Weight Calculation</p> <p>Eligibility:</p> <ul style="list-style-type: none"> • Height is between 152.4 – 241 cm (5 – 7.9 ft. OR 60 – 95 in) • Weight is between 20 – 400 kg (44 – 880 lbs.) • Patient is NOT pregnant <ul style="list-style-type: none"> ○ If the patient or is pregnant contact the TMP on call. ○ If the patient does not meet the minimum height requirement, enter their actual weight and a height of 152.4 cm into the ABW calculator to calculate Dosing Weight (ABW). <p>Step 1: Identify whether Option A or Option B has been chosen:</p>																														

Essential Tasks:

Option A: Prescriber Authorization for the IG Stewardship Program to calculate Adjusted Body Weight (Dosing Weight).

A. **PRESCRIBER AUTHORIZATION** for IG Stewardship Program to calculate Adjusted Body Weight (Dosing Weight) and total dose (grams) provided. Prescriber Initials: _____

Induction/One-time Dose: _____ g/kg; divided over ____ days (e.g. ITP: 1g/kg ABW)

Maintenance Dose: _____ g/kg; divided over ____ days

Repeat every ____ weeks for ____ cycles (Maximum 6 months for initial requests)

- Confirm prescriber has selected the tick box and initialed.

Option B: Prescriber NOT Authorizing the IG Stewardship Program to calculate Adjusted Body Weight (Dosing Weight).

B. If you are NOT authorizing the IG Stewardship Program to calculate Adjusted Body Weight, please provide: Adjusted Body Weight (Dosing Weight) _____ kg

- Use [AHS IVIG Adjusted Body Weight Calculator](#) to calculate dosing weight unless otherwise indicated

Induction/One-time Dose: _____ g/kg; = _____ g total; divided over ____ days

Maintenance Dose: _____ g/kg = _____ g total; divided over ____ days

Repeat every ____ weeks for ____ cycles (Maximum 6 months for initial requests)

- Confirm prescriber has selected the tick box and entered Adjusted Body Weight.

Step 2: Open the Alberta Health Services [IVIG Dosing Calculator](#)

- Enter patient's Sex (confirm on eHealth viewer if not indicated on order set), Height and Weight from section 4. **IVIG Order** on the order set. Calculate the Dosing Weight.

<p>IVIG Body Weight Calculator</p> <p>Enter Sex, Height & Weight, then click "Calculate".</p> <p>Sex: <input type="text" value="Male"/></p> <p>Height: <input type="text" value="170"/> cm (equals: 66.9 inches)</p> <p>Weight: <input type="text" value="102"/> kilograms (equals: 224.9 pounds)</p> <p><input type="button" value="Calculate"/></p> <p>Ideal Body Weight = 65.9 kg</p>	<p>IVIG Dose Calculator</p> <p>Select Dosing, then click "Calculate".</p> <p>Dosing: <input type="text" value="0.6"/> gram/kg</p> <p><input type="button" value="Calculate"/> using Dosing Weight</p> <p>IVIG Dose = _____ g</p>
<p>Dosing Weight (for obese or overweight patients) = 80.3 kg</p>	<p>IVIG Dose Rounded to Nearest 5 grams</p> <p>Rounded Dose = _____ g</p>

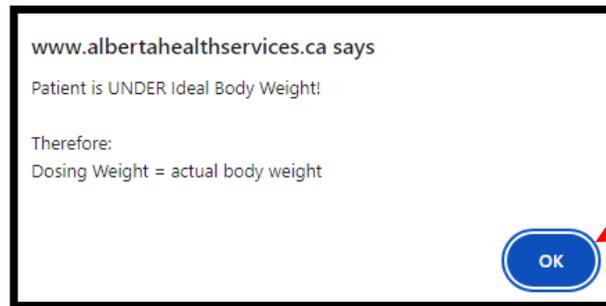
- Complete the *Calculated ABW* _____ kg in the Screening and Approval to be completed by IG Nurse Navigator or TML Box:

SCREENING AND APPROVAL TO BE COMPLETED BY IG NURSE NAVIGATOR OR TML	
<input type="checkbox"/> IV Immunoglobulin, 10%	OR <input type="checkbox"/> IV Immunoglobulin, 5% (<input type="checkbox"/> TMP approval confirmed)
<input type="checkbox"/> Specific IG Brand Requested (if applicable): _____	
<input checked="" type="checkbox"/> Calculated ABW _____ kg	<input type="checkbox"/> If required, total dose adjusted to _____ g
<input type="checkbox"/> Induction Dose _____ g; over ____ days	<input type="checkbox"/> TMP Consulted (Name) _____
<input type="checkbox"/> Maintenance Dose _____ g; over ____ days	Date Blood Consent Obtained: _____
<input type="checkbox"/> Approved for ____ cycles	Infusion Site/Facility: _____
IG NN/Tech Signature: _____	Estimated Start Date of POS: _____
Date: _____	

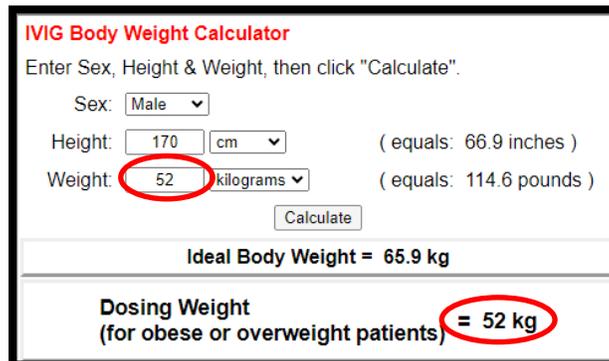
EssentialTasks:

Alberta Health Services Calculator Tips:

- If "Patient is UNDER Ideal Body Weight!" pop-up appears click ok.



- The Dosing Weight in the Adjusted Body Weight Calculator is now the patients Actual Body Weight.



- If patient is Under Ideal Body Weight or is pregnant use Actual Body Weight in the *Calculated ABW* _____ kg in the Screening and Approval to be completed by IG Nurse Navigator or TML Box.

Step 3: Using the IVIG Dose Calculator

- Enter the g/kg value found in **Section 5. Adjusted Body Weight (ABW) Calculation (select option A or B)** on the **ADULT Intravenous Immune Globulin (IVIG) Order Set section 5** into the IVIG Dose Calculator.
 - Option A:

<p>A. <input type="checkbox"/> PRESCRIBER AUTHORIZATION for IG Stewardship Program to calculate Adjusted Body Weight (Dosing Weight) and total dose (grams) provided. Prescriber Initials: _____</p> <p><input type="checkbox"/> Induction/One-time Dose: _____ g/kg; divided over _____ days (e.g. ITP: 1g/kg ABW)</p> <p><input type="checkbox"/> Maintenance Dose: _____ g/kg; divided over _____ days</p> <p>Repeat every _____ weeks for _____ cycles (Maximum 6 months for initial requests)</p>
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EssentialTasks:

- Option B:

B. If you are **NOT** authorizing the IG Stewardship Program to calculate Adjusted Body Weight, please provide: Adjusted Body Weight (Dosing Weight) _____ kg

- Use [AHS IVIG Adjusted Body Weight Calculator](#) to calculate dosing weight unless otherwise indicated

Induction/One-time Dose: _____ g/kg; = _____ g total; divided over _____ days

Maintenance Dose: _____ g/kg = _____ g total; divided over _____ days

Repeat every _____ weeks for _____ cycles (Maximum 6 months for initial requests)

- Click *Calculate* and an IVIG Dose will be calculated.

IVIG Dose Calculator

Select Dosing, then click "Calculate".

Dosing: 0.6 gram/kg

Using Dosing Weight

IVIG Dose = 53.7 g

- Confirm the IVIG Dose Rounded to Nearest 5 grams and the dose on the **ADULT Intravenous Immune Globulin Order Set** match.
- The rounded dose (to the nearest 5 grams) is the **final dose** to be delivered to the patient.

IVIG Dose Rounded to Nearest 5 grams

Rounded Dose = 55 g

Note:

- TML to round doses to the nearest 5 grams per the calculator.
- If the dose does not match and is not able to be rounded to the nearest 5 grams per the calculator contact the patient care unit.
- Any ADULT IVIG Order Set doses of 100g or more requested to be infused in a single 24-hour period shall be discussed with TMP on-call.

Step 4: Compare the recommended dose (g/kg) in the *Criteria for the Clinical Use of Immune Globulin* with the ordered dose.

- If the ordered dose does not match the recommended dose in the *Criteria for the Clinical Use of Immune Globulin*, contact the patient care unit to clarify.
 - If unable to clarify the ordered dose within one phone call reach out to TMP on call.

Step 5: Confirm number of cycles requested for Maintenance Dosing

- Initial Request: Maximum 6 months duration (26 weeks)
 - To calculate the maximum number of cycles divide the maximum 6 month duration (26 weeks) by the weekly interval on the POS.

Maintenance Dose: 35 g/kg; divided over 1 days

Repeat every 6 weeks for 6 cycles (Maximum 6 months for initial requests)

Essential Tasks:

- Example:
 - Order set states Repeat every 6 weeks for 6 cycles
 - 26 weeks divided by 6 cycles equals 4
 - Therefore the maximum number of cycles that can be approved are 4.

Note: The total number of cycles approved in the Screening and approval to be completed by IG Nurse Navigator or TML for this example would be 4.

SCREENING AND APPROVAL TO BE COMPLETED BY IG NURSE NAVIGATOR OR TML	
<input type="checkbox"/> IV Immunoglobulin, 10%	OR <input type="checkbox"/> IV Immunoglobulin, 5% (<input type="checkbox"/> TMP approval confirmed)
<input type="checkbox"/> Specific IG Brand Requested (if applicable): _____	
<input type="checkbox"/> Calculated ABW _____ kg	<input type="checkbox"/> If required, total dose adjusted to _____ g
<input type="checkbox"/> Induction Dose _____ g; over ___ days	<input type="checkbox"/> TMP Consulted (Name) _____
<input type="checkbox"/> Maintenance Dose _____ g; over ___ days	Date Blood Consent Obtained: _____
<input checked="" type="checkbox"/> Approved for <u>4</u> cycles	Infusion Site/Facility: _____
	Estimated Start Date of POS: _____
IG NN/Tech Signature: _____	Date: _____

6. Dividing IVIG Doses

Step 1: Total Dose

- Determine the final dose ordered and approved.

Step 2: Number of days

- Divide total dose over prescribed number of days.

Note: If the dose cannot be evenly divided, a difference of 5-10g between days is acceptable and does not pose a safety concern. Be sure to adjust the distribution in a way that prevents any waste of IVIG.

Additional Considerations:

- IVIG is supplied in different vial sizes.
- The way doses are divided depends on the brand and its available sizes.
- It does not matter which day the largest portion is administered, as long as the total dose is divided to prevent wastage.
- For Outpatient Orders administer the largest portion of the total dose on a day the patient is scheduled for a longer appointment.

7. Toxic Shock Syndrome IVIG Dose

Step 1: Adjusted Body Weight

- Verify that the ABW is calculated correctly using the Alberta Health Services [IVIG Dosing Calculator](#)

Step 2: Day 1 Dose

- Use the ABW Calculator to calculate **1g/kg ABW dose**.
- Confirm that the calculated dose matches the POS.

6. Toxic Shock Syndrome IVIG Dose	
<input type="checkbox"/> Schedule:	Day 1: 1 g/kg ABW = _____ g
	Day 2: 0.5 g/kg ABW = _____ g
	Day 3: 0.5 g/kg ABW = _____ g

Step 3: Day 2 Dose

- Use the ABW Calculator to calculate **0.5g/kg ABW dose**.

EssentialTasks:

- Confirm that the calculated dose matches the POS.

6. Toxic Shock Syndrome IVIG Dose

Schedule: Day 1: 1 g/kg ABW = _____ g
Day 2: 0.5 g/kg ABW = _____ g
Day 3: 0.5 g/kg ABW = _____ g

Step 4: Day 3 Dose

- Use the ABW Calculator to calculate **0.5g/kg ABW dose**.
- Confirm that the calculated dose matches the POS.

6. Toxic Shock Syndrome IVIG Dose

Schedule: Day 1: 1 g/kg ABW = _____ g
Day 2: 0.5 g/kg ABW = _____ g
Day 3: 0.5 g/kg ABW = _____ g

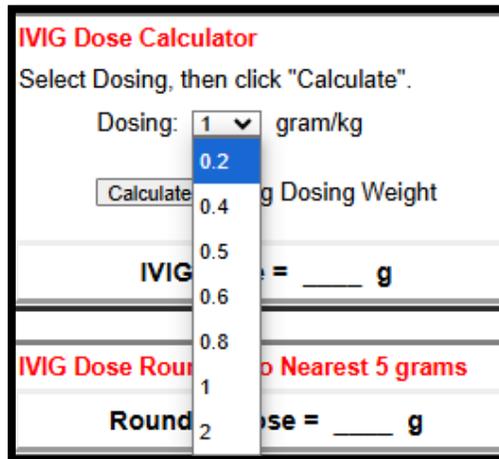
8. Tapering IVIG Dose

Step 1: Adjusted Body Weight

- Verify that the ABW is calculated correctly using the Alberta Health Services [IVIG Dosing Calculator](#)

Step 2: Confirm tapering schedule

- Use the ABW calculator to calculate the ABW dose and confirm dose matches the POS if applicable.
- The taper schedule may not always align with the dosing options provided by the Adjusted Body Weight (ABW) Calculator and may need to be calculated manually.
- The following dosing options are available directly in the ABW Calculator:



- For doses not listed (e.g., **0.7 g/kg**):
 1. Multiply the ABW by the prescribed dose in g/kg.
 - Example: If ABW = 52.3 kg and the taper dose is 0.7 g/kg, the calculated dose is 36.61 g
 2. Round the result to the nearest 5 g (e.g., 36.61 g rounds to 35 g).

Essential Tasks:

3. The prescribed dose for step one of the Tapering Schedule is **35 g**.

7. Tapering IVIG Dose

Tapering Schedule: 1) 0.7 g/kg = 35 g total; divided over 1 days
 Repeat every 4 weeks for 2 cycles THEN
 2) 0.6 g/kg = 30 g total divided over 1 days
 Repeat every 4 weeks for 2 cycles

9. Screening and Approval to be Completed by IG Nurse Navigator or TML Box

SCREENING AND APPROVAL TO BE COMPLETED BY IG NURSE NAVIGATOR OR TML

<input type="checkbox"/> IV Immunoglobulin, 10%	OR	<input type="checkbox"/> IV Immunoglobulin, 5% (<input type="checkbox"/> TMP approval confirmed)
<input type="checkbox"/> Specific IG Brand Requested (if applicable): _____		
<input type="checkbox"/> Calculated ABW _____ kg	<input type="checkbox"/> If required, total dose adjusted to _____ g	
<input type="checkbox"/> Induction Dose _____ g; over _____ days	<input type="checkbox"/> TMP Consulted (Name) _____	
<input type="checkbox"/> Maintenance Dose _____ g; over _____ days	Date Blood Consent Obtained: _____	
<input type="checkbox"/> Approved for _____ cycles	Infusion Site/Facility: _____	
IG NN/Tech Signature: _____		Date: _____
_____		_____

Step 1: Type and Brand

- Confirm type of IV Immunoglobulin noting 5% requires TMP approval.
- Complete Specific IG Brand Requested if applicable. If not applicable write N/A.

Step 2: Adjusted Body Weight

- Document the Calculated ABW regardless of whether option A or option B has been selected in **5. Adjusted Body Weight (ABW) Calculation**.

Step 3: IVIG Dosing

1. Calculate the Induction Dose using the ABW calculator if applicable and fill in the total grams ordered; over _____ days. Ensure the dose is rounded to the nearest 5g per ABW calculator. If no Induction Dose requested write N/A.
2. Calculate the Maintenance Dose using the ABW calculator if applicable and fill in the total grams ordered; over _____ days. Ensure the dose is rounded to the nearest 5g per ABW calculator. If no Maintenance Dose requested write N/A.
3. Complete the number of cycles approved.
4. Ensure any doses which have been changed in section **5. Adjusted Body Weight (ABW) Calculation** option B (either through rounding, prescriber clarification through nursing unit or TMP request) are written into the "If required, total dose adjusted to:"
5. If TM Physician has been consulted include the name of the TMP.

Step 4: IG NN/Tech Signature and Date

- Sign the IG NN/Tech Signature line and Date.

Note: The TMP on-call will notify the ordering physician unit if the order was not approved. Please fax the order set to the IG Stewardship Program and note order set was not approved.

10. Notification of hospital unit or

- For inpatient orders: MLTs shall fax the completed APPROVED ADULT Intravenous Immune Globulin Order Set back to the ordering unit.

Essential Tasks:	
infusion clinic and the IG Stewardship Program	<ul style="list-style-type: none"> • For urgent outpatient orders: MLT shall fax the completed APPROVED ADULT Intravenous Immune Globulin Order Set to the local infusion clinic. • MLT shall then either fax or email the screened and approved order set to the IG Stewardship Program at: <ul style="list-style-type: none"> ○ Email: igstewardshipprogram@saskhealthauthority.ca ○ Fax: 306-766-3509 <p><i>Note: An IG Nurse Navigator is available Monday-Friday 08:00-16:30 excluding statutory holidays.</i></p>
11. Issue IVIG	<ul style="list-style-type: none"> • Issue IVIG product per local protocol <ul style="list-style-type: none"> ○ Only proceed if the indication is approved and dosing appropriate

Appendices:

- Appendix A: ADULT Intravenous Immune Globulin (IVIG) Order Set
- Appendix B: Inpatient and Urgent Outpatient Adult IVIG POS Process Map
- Appendix C: Frequently Asked Questions – TML edition



PRACTITIONER ORDER SET

PATIENT INFORMATION

Site/Facility _____

ADULT Intravenous Immune Globulin (IVIG) Order Set

10% IVIG 5% IVIG



Allergies: See Regional Allergy / Intolerance Record OR:

Patient Height and Weight:
Refer to section 4 for Actual Height and Weight

To complete the order form, fill in required blanks and initial the appropriate boxes (☐).

Pre-checked boxes (☒) are initiated automatically. To delete orders, draw one line through the item and initial.

Processed (Initials)			
Care Plan	MAR/FAX	REQ	SCM

Send Completed Order Set to:

- Inpatient/Urgent Outpatient (infusion within 24 h): Fax to Local Transfusion Medicine Lab
- Outpatient: Fax 306-766-3509 OR E-mail igstewardshipprogram@saskhealthauthority.ca

Contact Information for Questions:

- IG Nurse Navigator: igstewardshipprogram@saskhealthauthority.ca or 306-766-3135
- Medical Consultation: Call switchboard at 306-655-1000 and ask for Transfusion Medicine Physician on call

1. Prescriber Information

Prescriber Full Name: _____ Specialty: _____
Phone Number: _____ Fax Number: _____

2. Blood Consent To Be Obtained by Prescriber

Blood Consent Obtained: (valid for up to one year and must be attached to order set)

3. Lab Investigations To Be Completed Prior to Initial Treatment

Prescriber to provide lab requisition for outpatient lab testing to patient

- ABO Group/Rh – must be completed prior to initial treatment; provide result if known _____
- CBC (repeat 7 – 10 days post infusion if group A, B, or AB to screen for hemolysis)

Patients receiving IG for primary or secondary immunodeficiency:

Serum immunoglobulin levels (IgA, IgG, IgM and IgE) (prior to initial treatment and annually)

4. IVIG Order

Prescriber to provide treating specialist's clinical notes supporting diagnosis and rationale for immunoglobulin treatment. Additional information may be required for adjudication.

- Diagnosis/Indication: _____
- Patient ACTUAL Height _____ cm Patient ACTUAL Weight _____ kg
- Specific IVIG Brand Requested (if applicable): _____

- Initial Request: Maximum 6 months duration
- Renewal Request: Maximum 12 months duration
- Tapered IVIG Dose: Proceed to Section 7

Criteria for Clinical Use



Practitioner: _____	PRINTED NAME	SIGNATURE	DATE/TIME
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Approved by: Department of Laboratory Medicine, Division of Transfusion Medicine, July 2024

Approved for use by: SHA Order Set Committee, July 2024

CS-OS-1910 January 6, 2025

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ADULT Intravenous Immune Globulin (IVIG) Order Set

10% IVIG 5% IVIG



To complete the order form, fill in required blanks and initial the appropriate boxes (☐).
Pre-checked boxes (☒) are initiated automatically. To delete orders, draw one line through the item and initial.

Processed (Initials)			
Care Plan	MAR/	REQ	SCM
FAX			

5. Adjusted Body Weight (ABW) Calculation (select option A or B):

Recommended maximum daily dose is 100 g

- A. **PRESCRIBER AUTHORIZATION** for IG Stewardship Program to calculate Adjusted Body Weight (Dosing Weight) and total dose (grams) provided. Prescriber Initials: _____
- Induction/One-time Dose: _____ g/kg; divided over _____ days (e.g. ITP: 1g/kg ABW)
- Maintenance Dose: _____ g/kg; divided over _____ days
Repeat every _____ weeks for _____ cycles (Maximum 6 months for initial requests)



- B. If you are **NOT** authorizing the IG Stewardship Program to calculate Adjusted Body Weight, please provide: Adjusted Body Weight (Dosing Weight) _____ kg
- Use [AHS IVIG Adjusted Body Weight Calculator](#) to calculate dosing weight unless otherwise indicated
- Induction/One-time Dose: _____ g/kg; = _____ g total; divided over _____ days
- Maintenance Dose: _____ g/kg = _____ g total; divided over _____ days
Repeat every _____ weeks for _____ cycles (Maximum 6 months for initial requests)

6. Toxic Shock Syndrome IVIG Dose

- Schedule: Day 1: 1 g/kg ABW = _____ g
Day 2: 0.5 g/kg ABW = _____ g
Day 3: 0.5 g/kg ABW = _____ g

7. Tapering IVIG Dose

- Tapering Schedule: 1) _____ g/kg = _____ g total; divided over _____ days
Repeat every _____ weeks for _____ cycles THEN
- 2) _____ g/kg = _____ g total divided over _____ days
Repeat every _____ weeks for _____ cycles

8. Medications

- A. **Pre-Infusion Medications:** (only order if patient has had a previous reaction to IVIG)
Administer 30 minutes prior to infusion:
- acetaminophen 650 – 975 mg PO x 1 for febrile reaction/headache (not to exceed 4,000 mg per 24 hours)
- hydrocortisone 100 mg IV x 1 for severe itch or rash
- cetirizine 10 mg PO x 1
- Other: _____
- Preventative Infusion Measures for IVIG Reactions:**
- Reduced infusion rate: MAXIMUM rate _____ mL/kg/h
- Headache prevention: Give _____ mL of _____ IV over _____ minutes prior to IVIG infusion

Practitioner:	_____	_____	_____
	PRINTED NAME	SIGNATURE	DATE/TIME

Appendix B: Outpatient Adult 10% IVIG POS Process Map

