



Name: _____ Date of Birth: _____

Allergies: _____

Diagnosis: _____ ICD-10 Code: _____

Ordering Physician Name (Print): _____

Insurance Info: _____

Pre-Medications to be given 30 minutes prior to start of infusion:

Acetaminophen 650mg PO Methylprednisolone 40 mg IV push Other: _____

Select ONE only:

Diphenhydramine 25 mg PO Diphenhydramine 50 mg PO
 Diphenhydramine 25 mg IV push Diphenhydramine 50 mg IV push Other: _____

Immune Globulin Intravenous (IVIG): All orders will be filled using Gammagard 10%, unless Gammagard S/D is medically necessary

Gammagard 10% Immune Globulin Intravenous
 Gammagard S/D 5% Immune Globulin Intravenous (brand medically necessary)

Weight based dose: _____ mg/kg calculated _____ grams (rounded to nearest 5 grams)

OR

Fixed dose: _____ grams (rounded to nearest 5 grams)

Frequency: _____

Assess for signs/symptoms of hypersensitivity &/or anaphylaxis:

- If signs/symptoms of reaction, administer Diphenhydramine 25 mg IV push (may repeat x1 in 15 minutes) AND Methylprednisolone 40 mg IV push
- Ondansetron 4 mg IV push x1 for nausea

Also required from physician office:

- History and Physical or Assessment and Plan or Physician Office Progress Note
- Insurance authorization

Authorization # and Dates (from and to): _____

Physician Signature: _____ Date: _____ Time: _____

Physician Office Phone: _____ Physician Office Fax: _____

(Fax order and medical record documentation to 412.942.3559)



Rate of Administration¹:

For all formulations, infusing too rapidly may cause a precipitous hypotensive reaction. Decrease rate of infusion at onset of patient discomfort or any adverse reactions. Decrease rate in patients at risk for neuromuscular disorders. IVIG products have been associated with renal dysfunction, acute renal failure, osmotic nephrosis, and death. For patients with any degree of renal insufficiency, age 65 years and older, with diabetes mellitus, paraproteinemia, sepsis, volume depletion, or known to be receiving nephrotoxic drugs: administer at the minimum rate of infusion practicable.

Gammagard 10% and Gammagard S/D 5% Immune Globulin

Initial Infusion Rate: 0.5 mL/kg/hour for the first 30 minutes,

If tolerated, infusion rate can be titrate as follows:

1 mL/kg for 30 minutes, then

1.5 mL/kg for 30 minutes, then

2 mL/kg for 30 minutes

Maximum infusion rate:

Drug/Indication	Primary Immunodeficiency (PI)	Multifocal Motor Neuropathy	Unspecified
Gammagard 10%	5 mL/kg/hr	5.4 mL/kg/hr	
Gammagard S/D 5%			4 mL/kg/hr

1. Collins, S.R. Intravenous Medications: A Handbook for Nurses and Health Professionals 38th ed. St. Louis, MO; Elsevier; 2022