Atrium Health Infusion Centers
Phone: 704-468-3400 **Fax:** 704-468-3401

Adult Gammagard S/D Infusion Order (Revised 4/3/21)

Instructions to provider: All orders with ☒ will be placed unless otherwise noted. Please fax completed order, along with referral form.

Required Lab Results: RN to draw IgG level every 3 months, CMP every 6 months

Infusion Therapy:

☐ Gammagard S/D _____gm IV over titratable rate **ICD 10 code:** _____
(dosing weight based on chart below)

☐ Over _____ day(s) ☐ **Frequency:** every _____weeks

Pre-Meds: **Administer 30 minutes prior to Gammagard S/D**

☐ Acetaminophen _____mg PO x 1

☐ Benadryl _____mg PO or _____mg IV x1 (*if applicable, only choose ONE*)

☐ SoluMedrol _____mg IV x 1

☐ Loratadine 10mg PO x 1

☐ Toradol _____ mg IV x 1 (*may be given pre- or post-infusion per patient preference*)

☐ Normal Saline 0.9% _____ mL x 1 to run over _____ mins or _____ hour(s)

Additional Orders:

_____

PRN Medications:

- Acetaminophen 500mg PO q4 hours PRN pain
- Zofran 4mg IVP q4 hours PRN nausea/vomiting
- Ibuprofen 800mg PO q8 hours PRN pain

Special Instructions:

- Follow Atrium Health Infusion Center protocol for hypersensitivity PRN.

Infusion Monitoring:

- Obtain vital signs pre- and post-infusion and every hour while infusing.
- Monitor for signs and symptoms of reaction for 30mins after initial infusion and subsequent infusions PRN.

Patient Description	Dosing Weight	Calculation Equation
Less than IBW	Actual Weight	Men: IBW (kg) = 50 + 2.3 X (height in inches over 60 inches) Women IBW (kg) = 45.5 + 2.3 X (height in inches over 60 inches)
Patients < 30 % over IBW	Ideal Body Weight	Men: IBW (kg) = 50 + 2.3 X (height in inches over 60 inches) Women IBW (kg) = 45.5 + 2.3 X (height in inches over 60 inches)
Patients > 30% over IBW	Adjusted Body Weight	Adjusted Body Weight (kg) = IBW + 0.4 X (Actual Body Weight – Ideal Body Weight)

Physician Name: _____

Physician Signature: _____

Date: _____ (order valid for 1 year)

Patient Name:

DOB:

MRN:

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