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

Pediatric Privigen 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: IgA level prior to first infusion. CBC with differential, creatinine within 3 months prior to each infusion.

Infusion Therapy:

☐ Privigen _____gm IV over titratable rate **ICD 10 code: _____**

Over _____ day(s)

Frequency: every _____weeks

Pre-Medications: **Administer 30 minutes prior to Privigen**

☐ Acetaminophen _____mg PO x 1

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

☐ SoluMedrol _____mg IV x 1

☐ Zofran _____mg IV x1 PRN nausea

Anaphylaxis Medications:

☐ Epinephrine (1:1000) _____ mg SQ/IM; may be repeated after 5mins

☐ SoluMedrol _____mg IV

☐ Benadryl _____mg IV

Additional Orders:

_____

_____

Special Instructions:

- Labs: _____ Frequency: **every infusion**
- Follow Atrium Health Infusion Center protocol for hypersensitivity PRN.
- Please monitor Vital Signs every hour while infusing and at completion of infusion.
- Monitor for signs and symptoms of reaction for 20mins after infusion.

Physician Name: _____

Physician Signature: _____

Date: _____ (order valid for 1 year)

Patient Name:

DOB:

MRN:

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Date: _____ (order valid for 1 year)

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