



Conveniently Located in East Syracuse, Onondaga Hill & Auburn

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IVIg (Gammunex-C) Non-Oncology Treatment Order Set

1. Patient Name: _____

2. DOB: _____ Height (inches): _____ Weight (lbs): _____

3. Diagnosis:

- G61.81 CIDP
- G61.0 Guillain-Barre Syndrome
- M33.9 Dermatopolymyositis
- M33.2 Polymyositis
- G70.1 Myasthenia Gravis w/ acute exacerbation
- G70.00 Myasthenia Gravis w/o acute exacerbation
- Other ICD-10 Code: _____ Diagnosis description: _____

4. Pre-medications:

- Acetaminophen: 1000mg PO 500mg PO
- Diphenhydramine: 25mg PO 50mg PO 25mg IV 50mg IV
- Hydrocortisone: 100mg IVP
- Other Pre-medication: _____
- No Pre-medications indicated

5. Drug Order:

IVIg (Gammunex- C)

Dose:

- _____ gram/kg/day
- _____ gram per day

Frequency:

- Daily x _____ Doses
- Every _____ Weeks
- Other: _____
- New to Therapy
- Continuing therapy: Last Dose Received _____ Next Dose Due _____

HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral

6. Infusion Lab Requirements:

- CBC & CMP within 2 weeks of therapy administration
- Other: _____
- No lab monitoring indicated

HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.

The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.

7. Required Baseline Lab/Testing Completed:

- CBC & CMP, Date _____
- Other: _____

8. Patient Assistance & REMS Program Enrollment

- Yes, patient has been enrolled in _____ program. (Provide Copy Enrollment Forms)
- No, patient has not been enrolled in any programs.

7. Physician's Name: _____ Phone: _____

Physician's Signature: _____ Date: _____

(This drug administration order form is valid for 12 months)