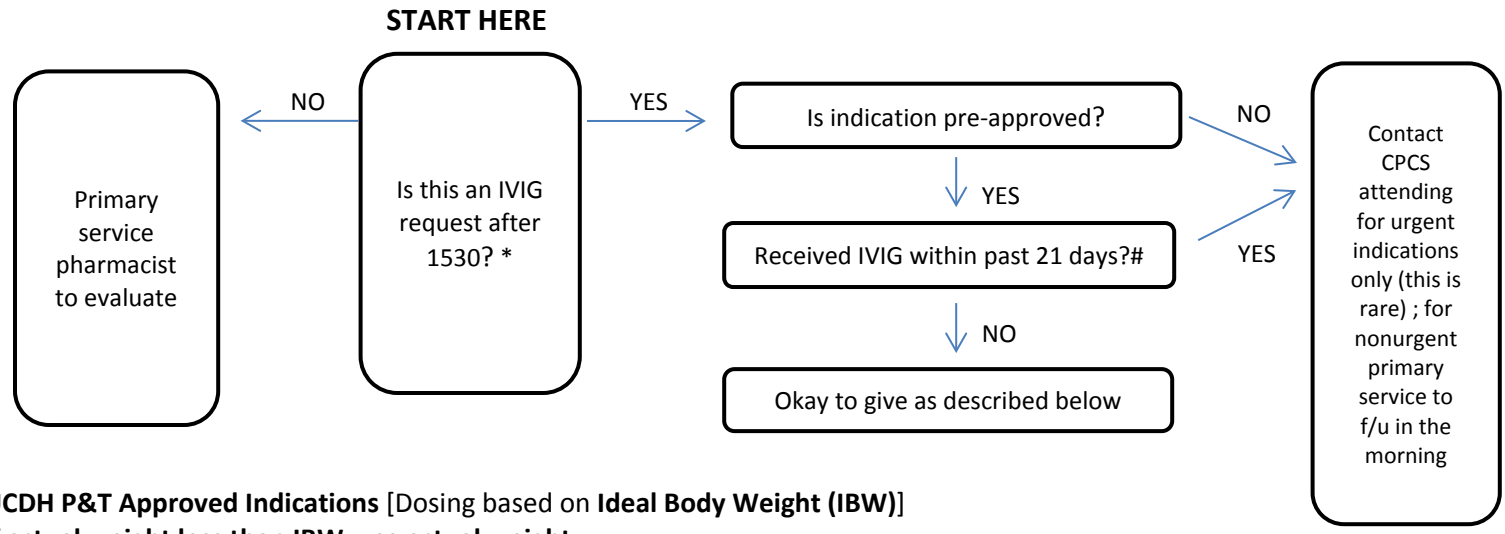

UCDH P&T Approved Indications [Dosing based on **Ideal Body Weight (IBW)**]
If actual weight less than IBW, use actual weight
NOTE: no testing for selective IgA deficiency required prior to administering IVIG

1) Primary humoral immunodeficiency

400-600 mg/kg X1 and then monthly dosing, adjusted to minimize infections and adverse effects. IgG levels may be followed to identify and maintain the patient-specific dosing that correlates with a minimal incidence of bacterial infections. If administering IgG supplementation to a patient with very low IgG levels, levels should be monitored bi-weekly or weekly to ensure adequate protection without allowing them to drop into the deficiency range, with the expectation that IgG level should increase by 250 mg/dL for every 100 mg/kg infused.

2) Idiopathic thrombocytopenic purpura (ITP), heme/onc pharmacist triage

required criteria: Plts < 10 or platelets < 20 with signs/symptoms of bleeding

Dose: 1 gram/kg x1, repeat dose may be consider after 48 hours to adequately evaluate response max 2 doses; repeat doses prior to 48 hours require CPCS attending approval

3) Neonates predisposed to GBS infection or children with HIV**,** pediatric pharmacist triage

Dose: 0.4 gram/kg x1

4) Kawasaki disease, pediatric pharmacist triage

Please see guideline for use.

Dose: 2 gram/kg x1. Second 2gram/kg x1, if still febrile36 hours after the first IVIG dose for up to 7 days

5) CLL with hypogammaglobulinemia and demonstrated recurrent bacterial infections, heme/onc pharmacist triage

Required criteria: Serum IgG <500 mg/dL

Dose: 0.4 gram/kg monthly

6) Multiple Myeloma with demonstrated recurrent bacterial infections, heme/onc pharmacist triage

Serum IgG levels may not correlate to functional IgG—level-based replacement is not required

Dose 0.4 gram/kg monthly

7) Streptococcal toxic shock syndrome, infectious disease pharmacist triage

Required criteria: Documented Streptococcal infection and hypotension plus evidence of end organ damage + ID note confirming

No ID note –call ID for note!

Dose: 1 gram/kg on Day 1, 0.5 gram/kg on Day 2 and Day 3

8) Guillain-Barre Syndrome

Variants can include: Acute Inflammatory Demyelinating Polyneuropathy (AIDP), Acute Motor Axonal Neuropathy, Acute Motor and Sensory Axonal Neuropathy, Miller Fisher Syndrome, Bickerstaff Encephalitis, Pharyngeal-Cervical-Brachial Weakness

Progressive weakness of more than one limb, ranging from minimal weakness of the legs to total paralysis of all four limbs, the trunk, bulbar and facial muscles, and external ophthalmoplegia.
Areflexia: While universal areflexia is typical, distal areflexia with hyporeflexia at the knees and biceps will suffice if other features are consistent. Neurology note confirming diagnosis.
Dose: 0.4 gram/kg/day x 5 doses

9) Myasthenia Gravis crisis
Required criteria: Neurology note confirming diagnosis
Dose: 0.4 gram/kg/day x 5 doses

10) Renal Transplant: Acute antibody-mediated rejection, transplant pharmacist triage
Required criteria: Detection of circulating anti-donor HLA antibody in recipient serum
Clinical findings: interstitial edema/hemorrhage, intravascular fibrin thrombi, vascular fibrinoid necrosis, plasma cell inflammatory infiltrate, immunohistochemical evidence of peritubular capillary C4d deposition
Dose: 0.5 gram/kg/day up to 4 doses, beginning within 24h after 5th plasmapheresis treatment OR 0.1 gram/kg beginning within 24h after first plasmapheresis treatment, then on alternating days after each subsequent plasmapheresis treatment.

11) Acute viral myocarditis in pediatric patients, pediatric pharmacist triage
Required criteria: LVEF <50% and three specialties must agree on diagnosis: pediatric primary team, pediatric ID, pediatric cardiology
Dose: 1 gram/kg X2 dose

12) Idiopathic Inflammatory Myopathy
required criteria: Active myopathy unresponsive to conventional therapy (or adverse drug reaction/contraindication to ongoing DMARD treatment (e.g. Methotrexate, Azathioprine, Mycophenolate, etc.) and with severe organ-threatening manifestations such as severe dysphagia unable to swallow and protect airway, weakness so severe patient unable to move increasing the risk of decubitus ulcer rash, or equivalent problem. See also, "Idiopathic Inflammatory Myopathy Refractory to Ongoing DMARD" guideline for more in-depth guidance.

Dose: 1 gram/kg X1 course (divided doses over 1-2 days)

13) Heart transplant acute antibody mediated rejection as described in Heart Transplant Clinical Protocol VI-5, cardiology pharmacist triage
Dose: 1 gram/kg (max 72 grams) daily X 2 days after last plasma exchange

14) Prophylaxis with IVIG in the post-partum period in patients with relapsing/remitting multiple sclerosis (RRMS).
Treatment requires insurance authorization for IVIG during post-partum period, including the initial dose in hospital (after delivery, prior to discharge) as well as follow-up doses during the extended post-partum period.

Dose: as authorized by insurance company **OR** 150 mg/kg X1 if the immediate post-partum dose is not specified as part of the insurance authorization.

Note: A patient may be approved for IVIG treatment *throughout* pregnancy, including the post-partum period.

15) Hyperbilirubinemia due to isoimmune hemolytic disease in infants 35 or more weeks of gestation, pediatric pharmacist triage
Administer 0.5-1.0 grams/kg IVIG (round to nearest vial size within range) if total serum bilirubin (TSB) is rising despite intensive phototherapy, or TSB is within 2-3 mg/dL of exchange level for age. If necessary, dose can be repeated in 12 hrs. If exchange transfusion is performed, additional doses of IVIG will not be approved. (AAP Clinical Practice Guideline – Pediatrics 2004; 114:297-316)

16) Acute Flaccid Myelitis, pediatric pharmacist triage

required criteria: Pediatric Neurologist or Pediatric Infectious Disease physician note confirming diagnosis based on acute onset of focal flaccid paralysis, MRI showing T2 hyperintensities in the spine with gray matter predominance spanning one or more segments, if imaging is questionable or normal then patient must have CSF pleocytosis (WBCs greater than 5).

Dose: 2 gram/kg X1 course (1g/kg q24 x 2 doses or 2g/kg divided doses over 3-5 days)

17) Multi-system Inflammatory Syndrome (MIS-C), pediatric pharmacist triage

See guideline for use.

18) post alloSCT heme/onc pharmacist triage

required criteria IgG less than or equal to 400 mg/dL

Can be repeated in 2 weeks to maintain IgG level above 400 mg/dL as half-life may be shortened in the post-transplant setting in comparison to healthy adults. All orders reviewed and assessed by primary pharmacist covering the service at the time of order placement; all orders should be flagged with CPCS i-vent to ensure follow-up and quality assurance review

19) Post CAR-T heme/onc pharmacist triage

required criteria IgG less than or equal to 400 mg/dL

*****Criteria not met: If after review by the primary pharmacist and specialized pharmacist the request does not meet guideline approval and the primary service is still pursuing IVIG, the primary service pharmacist will contact CPCS attending on-call. If non-urgent, wait until the following morning to follow up with primary service pharmacist

#If patient has not adequately responded by 2 weeks (or 3 months if idiopathic inflammatory myopathy) following the completion of IVIG infusion, the CPCS attending may refuse to approve the use of more IVIG or the requesting team must provide objective evidence from clinical studies that the additional/higher dose of IVIG is beneficial.

UCDH P&T UNAPPROVED indication:

post-partum MS prophylaxis without insurance authorization for extended post-partum treatment (denied 1/2019)

UCDH P&T UNAPPROVED indications (plasmapheresis is preferred as first-line if no absolute contraindication exists):

ANCA vasculitis

Catastrophic APS

Microangiopathic hemolytic anemia cases

Autoimmune Encephalitis