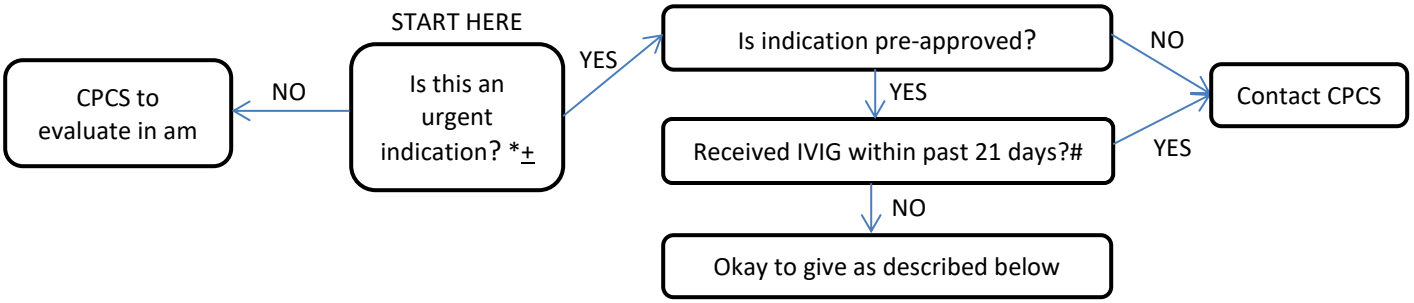

UCDH P&T Approved Indications [Dosing based on **Ideal Body Weight (IBW)**]

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

Plts <10, signs/symptoms of bleeding *****
Dose: 1 gram/kg x1, max 2 doses if needed

3) Neonates predisposed to GBS infection or children with HIV**±**

Dose: 0.4 gram/kg x1

4) Kawasaki disease

Please see guideline for use.*****
Dose: 2 gram/kg x1. Second 2g/kg dose, if still febrile 36 hours up to 7 days after end of first infusion.

5) CLL with hypogammaglobulinemia with demonstrated recurrent bacterial infections**±**

Serum IgG <500 mg/dL
Dose: 0.4 gram/kg monthly

6) Streptococcal toxic shock syndrome

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

7) Guillain-Barre Syndrome**±**

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

8) Myasthenia Gravis crisis**±**

Neurology note confirming diagnosis
Dose: 0.4 gram/kg/day x 5 doses

9) Renal Transplant: Acute antibody-mediated rejection**±**

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.

10) Acute viral myocarditis in pediatric patients**±**
Three specialties must agree on diagnosis: peds critical care, peds ID, peds cardiology
Dose: 2 gram/kg X1 dose

11) Idiopathic Inflammatory Myopathy**±**
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.
Dose: 1 gram/kg X1 course (divided doses over 1-2 days)

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

13) 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.

14) Hyperbilirubinemia due to isoimmune hemolytic disease in infants 35 or more weeks of gestation.
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)

15) Acute Flaccid Myelitis**±**
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 (divided doses over 3-5 days)

16) Multi-system Inflammatory Syndrome (MIS-C)
See guideline for use.*

*****If criteria not met: Call CPCS unless patient is in the ED and the ED pharmacist is here, then call ED pharmacist

±All orders to be evaluated by CPCS pharmacist; no call/page if CPCS pharmacist is not here.

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)