NZBLOOD
Te Ratonga Toto O Aotearoa

PRIVIGEN® Chart:
Intravenous Immunoglobulin (IVIg)

Check Twice. Chart Once.
Ensure the correct chart is selected.

Family Name: _____

Given Name: _____ Gender: _____

AFFIX PATIENT LABEL HERE

Date of Birth: _____ NHI#: _____

ALLERGIES:

Privigen® - Titration Schedule - 90 -150 minutes to titrate to maximum rate

Patient weight (kg) _____

Privigen® Titration Rates are weight-based, in **mL/kg/hour**. The prescriber must calculate the rate below.
The rate increases every 30 minutes, if tolerated, to a maximum of **2.4 mL/kg/hour** (TOTAL OF **4** INCREMENTS)

1. The first 30 minutes: 0.3 mL/kg/hour ⇒ Calculated: 0.3 x _____ weight in kg = _____ mL/hour
2. The next 30 minutes: 0.6 mL/kg/hour ⇒ Calculated: 0.6 x _____ weight in kg = _____ mL/hour
3. The next 30 minutes: 1.2 mL/kg/hour ⇒ Calculated: 1.2 x _____ weight in kg = _____ mL/hour
4. Thereafter, till end: 2.4 mL/kg/hour ⇒ Calculated: 2.4 x _____ weight in kg = _____ mL/hour

From the fourth maintenance dose, & **2 hours into the infusion**, the rate can increase from **2.4 mL/kg/hour** to a maximum of **4.8 mL/kg/hour** at 30 minute intervals, AND, if tolerated (TOTAL OF **6** INCREMENTS)

5. The next 30 minutes: 3.6 mL/kg/hour ⇒ Calculated: 3.6 x _____ weight in kg = _____ mL/hour
6. Thereafter, till end: 4.8 mL/kg/hour ⇒ Calculated: 4.8 x _____ weight in kg = _____ mL/hour

Privigen® - Induction Treatment: administered over 2- 5 days, as defined by the prescriber

☐ Induction Total Dose (g/kg) ..... Divided Over (number of days) .....

State clearly the daily dose in gram below; delete all 'day lines' not required. *COMPLETE PRESCRIBERS DETAILS & DIAGNOSIS

Date (dd/mm/yyyy)	Medication	Daily Dose (gram)	Route	Rate (mL/hr)	Prescribers Signature	Commenced by / Checked by	Date / Time
Day One	Privigen®		IV	As per titration above			
Day Two	Privigen®		IV	As per titration table above			
Day Three	Privigen®		IV	As per titration table above			
Day Four	Privigen®		IV	As per titration table above			
Day Five	Privigen®		IV	As per titration above			

*** Prescriber Details:** SMO / RMO

NZMC #	Name of Prescriber (print)	Signature	Initials	Designation	Contact Number

Administration Sample Signatures: Nurse/Midwife

Name (print)	Signature	Initials	Name (print)	Signature	Initials

Diagnosis / Reason for Privigen®:

Adult and Paediatric: PRIVIGEN® Chart - Intravenous Immunoglobulin (IVIg) 10% Solution

NZBLOOD
Te Ratonga Toto O Aotearoa

PRIVIGEN® Chart:
Intravenous Immunoglobulin (IVIg)

Check Twice. Chart Once.
Ensure the correct chart is selected.

Family Name: _____

Given Name: _____ Gender: _____

AFFIX PATIENT LABEL HERE

Date of Birth: _____ NHI#: _____

Patient weight _____ kg

Privigen® - Maintenance Treatment

☐ Maintenance Dose (g/kg) ..... every ..... weeks. *Complete Prescribers Details On Page 1

Date dd/mm/yyyy	Medication	Dose (gram)	Route	Rate (mL/hr)	Prescribers Signature	Commenced by / Checked by	Date / Time
	Privigen®		IV	As per titration table			
	Privigen®		IV	As per titration table			
	Privigen®		IV	As per titration table			
	Privigen®		IV	As per titration table			
	Privigen®		IV	As per titration table			
	Privigen®		IV	As per titration table			
	Privigen®		IV	As per titration table			
	Privigen®		IV	As per titration table			
	Privigen®		IV	As per titration table			
	Privigen®		IV	As per titration table			
	Privigen®		IV	As per titration table			
	Privigen®		IV	As per titration table			

Administration Sample Signatures: Nurse/Midwife

Name (print)	Signature	Initials	Name (print)	Signature	Initials

Diagnosis / Reason for Privigen®:

ADULT and PAEDIATRIC: PRIVIGEN® Chart - Intravenous Immunoglobulin (IVIg) 10% Solution