

PRIVIGEN® NZ 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® NZ - 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® NZ - 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® NZ		IV	As per titration above			
Day Two	Privigen® NZ		IV	As per titration table above			
Day Three	Privigen® NZ		IV	As per titration table above			
Day Four	Privigen® NZ		IV	As per titration table above			
Day Five	Privigen® NZ		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® NZ:

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



PRIVIGEN® NZ Chart:
Intravenous Immunoglobulin (IVIg)

Family Name: _____
 Given Name: _____ Gender: _____
AFFIX PATIENT LABEL HERE
 Date of Birth: _____ NHI#: _____

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Patient weight kg

Privigen® NZ - 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	Date
						Checked by	Time
	Privigen® NZ		IV	As per titration table			
	Privigen® NZ		IV	As per titration table			
	Privigen® NZ		IV	As per titration table			
	Privigen® NZ		IV	As per titration table			
	Privigen® NZ		IV	As per titration table			
	Privigen® NZ		IV	As per titration table			
	Privigen® NZ		IV	As per titration table			
	Privigen® NZ		IV	As per titration table			
	Privigen® NZ		IV	As per titration table			
	Privigen® NZ		IV	As per titration table			
	Privigen® NZ		IV	As per titration table			
	Privigen® NZ		IV	As per titration table			
	Privigen® NZ		IV	As per titration table			
	Privigen® NZ		IV	As per titration table			
	Privigen® NZ		IV	As per titration table			
	Privigen® NZ		IV	As per titration table			

Administration Sample Signatures: Nurse/Midwife					
Name (print)	Signature	Initials	Name (print)	Signature	Initials

Diagnosis / Reason for Privigen® NZ:

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