MADISON NEUROLOGY LLC

608 403 0000

Neurology Care 7 days a Week. Because Your Brain Matters.

IVIG

Immune globulin intravenous — Gamunex-C, Privigen, Gammagard Liquid, Octagam, Panzyga

COMPLETE CLINICAL PROTOCOL: PRE-TREATMENT CHECKLIST • ORDER SET • FOLLOW-UP • HOLD/DISCONTINUE CRITERIA

GENERIC NAME	immune globulin intravenous — Gamunex-C, Privigen, Gammagard Liquid, Octagam, Panzyga
BRAND	IVIG
MEDICATION CLASS	Pooled human immunoglobulin G (blood product)
PRESENTATION	10% (100 mg/mL) solutions in various vial sizes; sucrose-containing vs sucrose-free and sodium/sugar content differ BY PRODUCT — renal and tolerability profiles are not interchangeable
ROUTE	IV infusion with gradual, product-specific rate escalation
US INDICATION (FDA)	CIDP maintenance (FDA-labeled for select products), multifocal motor neuropathy (guideline-standard, off-label), acute MG exacerbation/crisis (guideline-standard, off-label), and other autoimmune neuropathies/neuroimmune conditions off-label.

Class context.
Boxed warnings: THROMBOSIS and ACUTE RENAL FAILURE. Both are mitigated the same way — hydration, slow maximum rates in at-risk patients, sucrose-free products in renal risk, and documented risk-factor screening. Product switches should be treated like a new start (full rate re-escalation).

Section 1 — Pre-Treatment Checklist

A. Required screening labs

☐ Serum IgA level — baseline. Selective IgA deficiency with anti-IgA antibodies → anaphylaxis risk; use an IgA-depleted product under specialist supervision or choose an alternative therapy.

☐ Renal function (creatinine, BUN, eGFR) — baseline and before each course; sucrose-containing products carry the highest renal risk and are avoided in renal impairment.

- ☐ CBC and blood group — baseline; hemolysis risk concentrates in non-O blood groups and high cumulative doses.
- ☐ Thrombosis risk inventory: age, immobility, prior VTE, hypercoagulable states, estrogen therapy, cardiovascular disease — these drive rate caps and product choice.
- ☐ Volume status — ensure hydration before and during the course (renal protection).
- ☐ Pregnancy test when relevant.

B. Vaccinations

- ☐ High-dose IVIG blunts live-vaccine responses: defer MMR/varicella for an extended interval after high-dose courses per ACIP (up to ~8–11 months after 2 g/kg); document timing and advise primary care.

C. Clinical assessments & counseling

- ☐ Document the indication, weight for dosing, and an OBJECTIVE baseline deficit (INCAT for CIDP; MG-ADL for MG) — continuation depends on measurable response.
- ☐ Product-selection review: renal function (sucrose-free), IgA status, diabetes (glucose-containing products), sodium load (cardiac/renal patients).
- ☐ Counsel on common effects (headache, chills, myalgia, flushing) and red flags: severe headache with neck stiffness (aseptic meningitis), dark urine (hemolysis), chest pain/dyspnea, unilateral leg swelling (thrombosis).

D. Exclusion / hold criteria — do not start

CRITERION	RATIONALE / REQUIRED ACTION
History of anaphylaxis to immunoglobulin products	Do not administer outside a specialist desensitization protocol.
Selective IgA deficiency with anti-IgA antibodies	Relative contraindication — specialist-directed only with IgA-depleted product.
Acute renal failure / severe renal impairment	Avoid sucrose-containing products; reconsider therapy and rate.
Acute thromboembolic event or hypercoagulable crisis	Defer; reassess risk.

Section 2 — Order Set

Premedication

- ☐ Optional: acetaminophen 650 mg PO + diphenhydramine 25–50 mg PO/IV ~30 minutes before infusion — routine for first exposures and after prior mild reactions.
- ☐ Hydration: oral or IV fluids before the infusion; continue through multi-day courses.

Dosing schedule

CIDP load / MG exacerbation	2 g/kg total, divided over 2–5 consecutive days (split to keep each day ≤1 g/kg and reaction-manageable).

CIDP maintenance	Commonly 1 g/kg every 3 weeks (range 1–2 g/kg every 2–6 weeks), individualized to response (labeled maintenance for Privigen in CIDP: 1 g/kg q3w).
MMN maintenance	Commonly 1–2 g/kg every 2–4 weeks (guideline-based).
Rate	Start low per the specific product insert (e.g., ~0.5 mg/kg/min), escalate stepwise to the product maximum ONLY as tolerated; cap rates lower in renal, cardiac, or thrombosis risk.
Reaction rule	Slow or STOP for headache, chills, flank pain, chest tightness, or dyspnea; mild reactions may resume at a lower rate once resolved.

Standing orders — every infusion

- ☐ Vital signs at baseline, each rate change, and completion.
- ☐ Maintain hydration throughout multi-day courses.
- ☐ Document product, lot, dose, rates, and reactions for every exposure (blood-product traceability).
- ☐ Treat ANY product change as a new start: full rate escalation from the beginning.

Missed or delayed dose

Resume maintenance as soon as feasible; after a long gap with returned symptoms, consider re-loading at 2 g/kg.

Section 3 — Follow-Up Protocol

ITEM	FREQUENCY / TIMING	ACTION / THRESHOLD
Renal function	Baseline and periodically; more often with sucrose-containing products or renal risk	Creatinine rise → hold, hydrate, change product.
CBC / hemolysis markers	After early courses, or if symptomatic (fatigue, dark urine)	Confirmed hemolysis → hold; subsequent use needs specialist risk review.
Objective disease score (INCAT / MG-ADL)	Every cycle for the first 6 months, then at dose-optimization reviews	No measurable benefit at adequate dose → do not continue maintenance.
Annual de-escalation trial (CIDP)	At least yearly	Test dose reduction or withdrawal — some patients no longer need treatment; continuing without this is overtreatment.
IgG trough (if used to individualize)	Per institutional practice	Troughs guide interval adjustments in some protocols.

Section 4 — Pause vs. Stop Criteria

A. Pause or delay (resume when resolved)

CRITERION	REQUIRED ACTION
Acute kidney injury	Hold; hydrate; review product selection.

Moderate infusion reaction not resolving with rate reduction	Defer the remaining dose.
Intercurrent acute illness	Defer as appropriate.

B. Discontinue permanently

CRITERION	REQUIRED ACTION
Anaphylaxis	Stop; emergency management.
Confirmed hemolysis, thromboembolic event, or aseptic meningitis attributed to IVIG	Stop; any future use requires specialist risk review.
Loss of objective response at an adequate dose	Stop maintenance — document the de-escalation outcome.

Section 5 — Notes & Practical Points

- ☐ Dose individualization is the whole craft of IVIG maintenance: titrate DOWN to the lowest effective dose, and re-prove need annually.
- ☐ Neuromuscular IVIG is weight-based and product-specific — the order should name the product, not just 'IVIG'.

Prepared November 2026 by Madison Neurology LLC.

This document is an educational compilation and does not reproduce the complete prescribing information. Verify every element against the current FDA label and applicable REMS requirements before clinical use.

- Current U.S. prescribing information via NIH DailyMed — https://dailymed.nlm.nih.gov/dailymed/
- FDA Drugs@FDA database — https://www.accessdata.fda.gov/scripts/cder/daf/
- FDA drug safety and availability updates — https://www.fda.gov/drugs/drug-safety-and-availability

Questions about infusion referrals: call 608 403 0000. Neurology Care 7 days a Week. Because Your Brain Matters.