Interior Health

IVIG (Intravenous Immune Globulin) REQUEST - Transfusion Medicine (TM)

Patient Name _____

Site MRN _____

Date of Birth _____

PHN _____

Requesting Physician _____

Completion of both pages (items #1 – 10) is required before request will be processed and IVIG released. Both pages must be submitted with patient demographics to ensure the request is for correct patient.

1. IS REQUEST URGENT?	☐ Yes ☐ No	Inpatient? ☐ Yes ☐ No Facility where patient will get IVIG: _____
2. CHECK ONE See IH IVIG Reference #828651	☐ Patient meets established criteria for IVIG listed on IH IVIG Reference; select from conditions below. ☐ Medical condition not listed (specify) _____ Provide supporting evidence of efficacy. Initial therapy will be limited to 3 month trial if approved.	

3. APPROVED INDICATIONS AND POSSIBLE NEUROMUSCULAR INDICATIONS *(select one)*

Immunology
- ☐ Primary Immune Deficiency (PIDD)
- ☐ Secondary Immune Deficiency (SID)
  - additional documentation will be provided by the IH IVIG Coordinators

Hematology
- ☐ Idiopathic Thrombocytopenic Purpura (ITP) – adult
- ☐ Idiopathic Thrombocytopenic Purpura (ITP) – pediatric
- ☐ Fetal-Neonatal Alloimmune Thrombocytopenia (F/NAIT)
- ☐ Hemolytic Disease of the Newborn (HDN)

Neurology
- ☐ Guillain-Barré Syndrome (GBS), including Miller-Fisher Syndrome
- ☐ Multifocal Motor Neuropathy (MMN)
- ☐ Myasthenia Gravis (MG)
- ☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

Dermatology
- ☐ Pemphigus Vulgaris (PV)

Infectious Diseases
- ☐ Infectious Staphylococcal Toxic Shock (STS)
- ☐ Invasive Group A Streptococcal Fasciitis with associated Toxic Shock (IGAS)
- ☐ Measles - Post Exposure Prophylaxis (MPEP)

Rheumatology (for patients age 18 and under)
- ☐ Juvenile Dermatomyositis (JD)
- ☐ Kawasaki Disease (KD)

IVIG for patients over 18 years of age with Rheumatological conditions must be pre-approved by Provincial Blood Coordinating Office (PBCO) Rheumatology IVIG panel. The Adult Rheumatology IVIG Request form is available from PBCO website www.pbco.ca or IH IVIG Coordinator. A provincial rheumatologist is on call Monday to Friday during regular business hours

Possible Neuromuscular Indications
(see IH IVIG Reference #828651)
- ☐ *Atypical/Possible Chronic Inflammatory Demyelinating Polyneuropathy (ACIDP)*
- ☐ *Refractory Vasculitic Neuropathy (RVN)*
- ☐ *Lambert Eaton Syndrome (LE)*
- ☐ *Sensory Ganglionopathy (SG)*
- ☐ *Stiff Person Syndrome (SPS)*
- ☐ *Severe Diabetic Radiculoplexopathy (SDR)*
- ☐ *Voltage Gated K+ Channelopathy (VGKC)*
- ☐ *Other Neuromuscular conditions*

(specify): _____

4. PRESCRIBING PRIVILEGES	☐ I **have** prescribing privileges at this facility and I will write prescription orders for infusion. ☐ I **do not** have prescribing privileges and physician will write/co-sign prescription orders for infusion.***** *(Physician Name)* _____

Continued on next page. →

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5. BLOODWORK REQUIRED	Pre-infusion IgG level for PIDD / SID: _____ g / L Pre-infusion platelet count for ITP: _____ 109 / L ABO / Rh type to determine risk of IVIG related hemolysis: _____		
6. WEIGHT AND HEIGHT	Weight _____ kg Height _____ cm Dosing Weight (DW): _____ kg Go to www.pbco.ca and click on the icon ⊕ DOSE CALCULATOR to calculate the IVIG dose based on dosing weight. (Dosing weight not applicable to pediatric or pregnant patients. Use actual weight.)		
7. INDUCTION DOSING	☐ 0.4 g / kg dosing weight ☐ 1 g / kg dosing weight ☐ 2 g / kg dosing weight ☐ Other (specify) _____		
7a. DOSE	Transfuse _____ grams IVIG every 24 hours × _____ day(s). (Dose will be rounded down to nearest vial size)		
8a. MAINTENANCE DOSING	☐ 0.4 g / kg dosing weight ☐ 1 g / kg dosing weight ☐ 2 g / kg dosing weight ☐ Other *(specify)* _____		
8a. DOSE	Transfuse _____ grams IVIG every 24 hours × _____ day(s). (Dose will be rounded down to nearest vial size)		
8b. REPEAT EVERY	☐ month ☐ _____ week(s) ☐ _____ day(s) × _____ cycle(s) ☐ no repeats		
9. REQUESTING PHYSICIAN	Signature	MSP #	Date (dd / mm / yyyy)
10. PRESCRIPTION ORDER*	Complete IH Physician's Order form 826165 or site specific booking form and send to clinical area. Include patient demographics, location, scheduling / urgency requirements, dosage, transfusion rate, and pre- or post-medications.		

Send completed form to IH IVIG Coordinator, fax **250-862-4052**. If request is urgent or IH IVIG Coordinator is not available, **send to hospital TM / Lab** where patient will get IVIG. IH Labs have an after hours IVIG Request Procedure and Job Aid.

Laboratory use only. Screening note:		
Hematopathologist / Pathologist Signature	MSP #	Date (dd / mm / yyyy)