Interior Health

INTRAVENOUS IMMUNE GLOBULIN (IVIG) REQUEST – TRANSFUSION MEDICINE (TM)

Patient Name *(last)* _____

(first) _____

DOB *(dd/mmm/yyyy)* _____

PHN _____ MRN _____

Account/Visit # _____

IH USE ONLY

Instructions:

1. Complete all sections below. ***The approval/release process will be deferred until required documentation is submitted.***
2. Submit for approval to IH IVIG Coordinators by **fax 250-862-4131**. If urgent, send form to hospital TM/LAB where patient will receive IVIG. All requests are screened per BC Immunoglobulin Utilization Management Program.

1. Transfusion Location _____

☐ **I have prescribing privileges at this facility and I will write the prescription orders for IVIG transfusion.**

☐ **I do not have prescribing privileges and** *(physician name)* _____ **will co-sign transfusion orders.**

2. Approved Conditions - See Provincial Blood Coordinating Office Programs for more information www.pbco.ca

Immunology

☐ Primary Immune Deficiency (PIDD)

- Secondary Immune Deficiency (SID) (use form #826795 for initial request or #826796 for renewal request) **DO NOT USE THIS FORM**

Hematology

☐ Idiopathic Thrombocytopenic Purpura (ITP)

☐ Fetal-Neonatal Alloimmune Thrombocytopenia (F/NAIT)

☐ Hemolytic Disease of the Newborn (HDN)

Infectious Diseases

☐ Staphylococcal Toxic Shock (STS)

☐ Invasive Group A Streptococcal Fasciitis with associated Toxic Shock (IGAS)

☐ Measles - Post Exposure Prophylaxis (MPEP)

Dermatology

☐ Pemphigus Vulgaris (PV)

Neurology/Possible Neuromuscular Indications

- see Form #826797

Rheumatology (for patients age 18 and under)

☐ Juvenile Dermatomyositis (JD)

☐ Kawasaki Disease (KD)

- IVIG for patient over 18 years of age must be approved by the Provincial Rheumatology Panel

Other

☐ Medical condition not listed *(specify):* _____

3. Bloodwork Required

☐ Pre-infusion IgG level for PIDD: _____ g / L

☐ Pre-infusion platelet count for ITP: _____ 10^9 / L

4. Weight and Height

Weight: _____ kg

Height: _____ cm

Adjusted Body Weight (ABW) _____ kg

Dosing Calculator: www.pbco.ca

5. Induction Dose

☐ 0.4 g/kg (ABW) ☐ 1 g/kg (ABW) ☐ 2 g/kg (ABW) ☐ **Other** *(specify):* _____

Transfuse _____ grams IVIG every 24 hours × _____ day(s)

6. Maintenance Dose

☐ 0.4 g/kg (ABW) ☐ 1 g/kg (ABW) ☐ 2 g/kg (ABW) ☐ **Other** *(specify):* _____

Transfuse _____ grams IVIG every 24 hours × _____ day(s)

Frequency: ☐ monthly ☐ q4 weeks ☐ every _____ days for ☐ 6 courses ☐ other

7. Requesting Physician and Medical Services Plan number (MSP #): _____

Date (dd/mmm/yyyy)	Time (24 hour)	Physician Name/Signature	Initials	College ID #

Hematopathologist / Pathologist Screening Note ☐ **Approved** ☐ **Denied** ☐ **Deferred to expert**

Date (dd/mmm/yyyy)	Time (24 hour)	Printed Name	Signature	Initials	Designation / College ID #