Ontario

MOHLTC IVIG Request Form

For non-neurology use only

Patient Name
ID #
D.O.B.
Gender
Location
HC#
ALL FIELDS MANDATORY

Date Requested: (YYYY/MM/DD)	Treating Physician:
Date Required: (YYYY/MM/DD)	Physician Specialty:

Dosage Information **(Verification of dose using Dose Calculator tool is recommended. Refer to http://ivig.transfusionontario.org/dose)**

Patient Weight: _____ kg Patient Height: _____ cm	BMI _____ **Dose must be adjusted for BMI greater than or equal to 30** http://ivig.transfusionontario.org/bmi Dose Calculator Used? ☐ Yes ☐ No If No, why was it not used? _____
☐ Induction/One-time dose	_____ g/kg = _____ g; divided over _____ days
☐ Maintenance dose	_____ g/kg= _____ g; divided over _____ days; _____ weeks; Duration: _____ months
IgG level/Platelet count/other test results relevant to patient condition: Result: Date:	

Clinical Indication for use must be recorded below

Medical Condition	Suggested initial dose and duration
☐ Fetal/Neonatal Alloimmune Thrombocytopenia (F/NAIT)	*Maternal*: Previous fetus with intracranial hemorrhage: Up to 2 g/kg/week. No previous fetus with intracranial hemorrhage: Up to 1 g/kg/week. *Infant*: Initial dose of 1 g/kg then reassess.
☐ Hematopoietic Stem Cell Transplant in primary immunodeficiency	0.4-0.6 g/kg every 4 weeks Requirements may increase and should be based on clinical outcome.
☐ Hemolytic Disease of the Fetus and Newborn (HDFN)	0.5 g/kg over 4 hours.
☐ Idiopathic Inflammatory Myopathy (IIM) Includes Dermatomyositis and Polymyositis	*Initial Dose*: Maximum of 2 g/kg divided over 2 days.
☐ Immune Thrombocytopenia (ITP) Adult ☐ Immune Thrombocytopenia (ITP) Pediatric	*Acute*: 1 g/kg as a single dose. Repeat if no clinical response. *Chronic*: 1-2 g/kg. Alternate approaches should be considered. *Pediatric*: 0.8 -1 g/kg. Repeat if no clinical response.
☐ Invasive Group A streptococcal fasciitis with associated toxic shock ☐ Staphylococcal Toxic Shock	1 g /kg on day one and 0.5 g/kg per day on days 2 and 3 **OR** 0.15 g/kg per day for 5 days.
☐ Juvenile Idiopathic Inflammatory Myopathy (J-IIM) (previously Juvenile Dermatomyositis)	*Initial Dose*: Maximum dose of 2 g/kg divided over 2 days.
☐ Kawasaki Disease (KD)	2 g/kg for 1 day. Second dose can be given for patients that fail to respond to initial dose.
☐ Kidney transplant from living donor to whom the patient is sensitized	2 g/kg/month for 4 months.
☐ Pemphigus Vulgaris and variants	Total dose of 2 g/kg divided over 2 to 5 days.
☐ Post-transfusion Purpura	Up to 2 g/kg divided over 2 to 5 consecutive days. Repeat if necessary.
☐ Pre-transplant (Heart)	Up to 1 g/kg/month until transplant.
☐ Peri-transplant (heart, lung, kidney, pancreas)	1 g/kg can be divided if in association with a course of plasmapheresis.
☐ Post-transplant antibody mediated rejection	*Acute*: 1 g/kg. Can be given as divided doses if in association with a course of plasmapheresis. *Chronic*: 1 g/kg/month.
☐ Primary Immune Deficiency (PID) ☐ Secondary Immune Deficiency (SID)	*Adult*: 0.4-0.6 g/kg every 4 weeks. *Pediatric*: 0.3-0.6 g/kg every 4 weeks.
****Other Requires Approval** Clinical diagnosis and/or indication for IVIG request:	

** For Transfusion Medicine Use Only

☐ **Dose verified** ☐ **Dose adjusted to:**	**By (signature req'd):**
☐ **Confirmed with ordering physician**	**Date:**
☐ **Approved** ☐ **Denied**	
Signature of Approving Physician:	**Date:**

Please fax/send to:

Use of the MOHLTC Intravenous Immune Globulin Request Form

Conditions

This form is to be used for all non-neurology IVIG requests.

Where a request includes multiple infusions of IVIG (e.g. a course of treatment rather than a single infusion), completing the form once is sufficient, until:

a) Dose is modified, or
b) Six months have elapsed since the initial treatment was prescribed (all conditions except Primary Immune Deficiency), or
c) Twelve months have elapsed since the initial treatment for Primary Immune Deficiency.

Completing the Form

Treating Physician or Designate

1. Complete the date requested and the date required using format YYYY MM DD.
2. Identify treating physician and their specialty e.g. Hematology, Dermatology etc.
3. Document the patient height and weight.
4. Calculate the BMI.
5. Identify the total dose per treatment using the dose calculator if appropriate.*
6. Record IVIG dose and duration of therapy.
7. Check the "Dose calculator used" box if dose was confirmed using the dose calculator. **
8. Check the appropriate box to indicate the clinical indication explaining the request (e.g. check box beside Immune Thrombocytopenia).
9. Check 'Other' if the clinical indication does not appear on the list; requests for 'Other' indications are subject to screening.
10. Document the platelet count in ITP, IgG level in PID and SID or other relevant test results as required.
11. Evaluate the clinical outcomes of patients to ensure the treatment continues to be effective and appropriate.

Health care professional receiving the request (e.g. laboratory technologist, pharmacy personnel)

1. Verify that the clinical indication coincides with one of the clinical indications listed. If not, proceed to step 4.
2. Verify the dose requested using the dose calculator if appropriate.
3. Doses that require adjustment must be confirmed with the treating physician and documented on the bottom of the form.
4. Requests listing 'Other' as the clinical indication should be referred to an approving physician for screening.

Approving Physician or Designate

1. Screening of all IVIG requests for clinical indications listed under 'Other' is required.
2. Document whether the request is approved or denied using the shaded area at the bottom of the request form including a signature, date and checking the appropriate box.

Supplementary Information

IVIG will always be provided in life-threatening situations.

Hemolytic reactions due to anti-A and/or anti-B in IVIG have been noted.

Patients should be monitored for signs of hemolysis.
CBC, Blood Group and Antibody Screen should be ordered prior to initial infusion.
In Group A, B or AB patients, within 1 week of initial infusion the following tests are recommended:
CBC, Direct Antiglobulin Test, total and direct bilirubin, retic, LDH, and haptoglobin.

***Institutions who do not adopt the dose calculator tool are required to enact an alternative strategy for adjusting the dose for obese patients.**
****Use of the dose calculator may not be applicable for maintenance therapy.**