

Patient Identifier:

Name: _____

PHN: _____

DOB: _____

**Intravenous Immune Globulin (IVIG)
Subcutaneous Immune Globulin (SCIG) Physician
Request Form**

INITIAL TREATMENT

Date of Completion: _____

<input type="checkbox"/> IVIG		<input type="checkbox"/> SCIG	
Patient Weight (kg): _____		BMI _____ Dose must be adjusted for BMI greater than or equal to 30 http://ivig.transfusionontario.org/dose/	
Patient Height (cm): _____		Dose calculator used? _____ If no, why was it not used? _____	
<input type="checkbox"/> Single _____ g/day x _____ days, q _____ weeks			
<input type="checkbox"/> _____ Treatments _____ g/day x _____ days, q _____ weeks Duration: _____ months			
IgG level/Platelet count/other test results relevant to patient condition:			
Result: _____		Date: _____	
Required: Ordering Physician (print): <i>(must be an approved prescriber)</i>			
Physician's First and Last Name: _____		Specialty: _____	
License #: _____		Physician signature: _____ Consulting Physician: _____	
CLINICAL INDICATION (required):			
Dermatology	<input type="checkbox"/> Pemphigus Vulgaris		
Hematology	<input type="checkbox"/> Hemolytic disease of the fetus and newborn	<input type="checkbox"/> ITP	
	<input type="checkbox"/> Neonatal alloimmune thrombocytopenia	<input type="checkbox"/> Post transfusion purpura	
Immunology	<input type="checkbox"/> Primary immune deficiency		
	<input type="checkbox"/> Secondary immune deficiency (Primary diagnosis: _____)		
	<input type="checkbox"/> Limbic (immune) encephalitis		
Infectious Disease	<input type="checkbox"/> Recurrent or serious infection		
	<input type="checkbox"/> Group A Streptococcal fasciitis	<input type="checkbox"/> Staphylococcal Toxic Shock	
Neurology	<input type="checkbox"/> Chronic Inflammatory Demyelinating Polyneuropathy	<input type="checkbox"/> Multifocal Motor Neuropathy	
	<input type="checkbox"/> Guillain-Barré syndrome	<input type="checkbox"/> Myasthenia Gravis	
	<input type="checkbox"/> Lambert-Eaton Myasthenic syndrome	<input type="checkbox"/> Stiff person syndrome	
Rheumatology	<input type="checkbox"/> Dermatomyositis	<input type="checkbox"/> Kawasaki Disease	
	<input type="checkbox"/> Polymyositis		
(Other) If clinical indication does not appear on this list:			
Diagnosis: _____			
Infusion site:			
<input type="checkbox"/> WRHA		<input type="checkbox"/> Northern	<input type="checkbox"/> Prairie Mountain
<input type="checkbox"/> Interlake-Eastern		<input type="checkbox"/> Southern	<input type="checkbox"/> CCMB
Institution: _____			
Changes to treatment:			
<input type="checkbox"/> Dose changed		<input type="checkbox"/> New Patient	<input type="checkbox"/> Patient deceased
<input type="checkbox"/> Subcutaneous route		<input type="checkbox"/> 6 month renewal	Date: (mm/dd/year) _____
Multiple Infusion patients:			
<input type="checkbox"/> Treatment discontinued		<input type="checkbox"/> Recurring Patient	

All requested information must be provided. The issue of product will not occur unless completed form is received.

Completion of Intravenous Immune Globulin (IVIG) and Subcutaneous Immune Globulin (SCIG) Physician Request Form

This form shall accompany a Request to Release form and is required for:

1. Initial order for one time infusion.
2. Initial order for multiple infusions.
3. Follow up evaluation shall be completed after the first 6 months of treatment and then every six months for multiple infusions. Please use Follow Up form for future infusion orders.

The Physician or designate instructions for completion:

Note: Ordering Physician must be on the Approved Prescriber list which can be found on the Best Blood Manitoba website at <http://bestbloodmanitoba.ca/for-clinicians/>

1. Addressograph or use patient identification sticker.
2. Complete **Date of Completion**.
3. Complete the preferred IVIG formulation.
4. Document the patient's height and weight.
5. Identify the total dose per treatment and the duration of the treatment. An online adjusted body weight calculator is available at <http://ivig.transfusionontario.org/dose/> or <http://www.pbco.ca/IVIG Dosing Calculator.htm> or see below under Dosing Guidelines.
6. Identify the **Ordering Physician**, their **Specialty** and, if a consult has occurred, the **Consulting Physician**.
7. Check the appropriate box to identify the **Clinical Indication**.
8. Check **Other** if the Clinical Indication does not appear on the list.
9. Identify the **Infusion Site** or where SCIG will be obtained.
10. Indicate if the form completion is due to **Changes to Treatment**.

Blood Bank Instructions:

1. Verify the **Ordering Physician** is on approved list of prescribers and all information is complete.
2. Return to sender if information is missing along with the Request to Release form.
3. Add patient name, PHIN, physician and date to the IVIG site specific patient log.
4. Keep copy of form in blood bank.
5. Fax Form to Blood Management Service, 204-940-3255.

Dosing Guidelines:

Dosing Weight is an adjusted body weight of obese or overweight patients used to calculate the dose of drugs for which there are recommendations specifying that the actual body weight should be adjusted for use in the dose calculations.

Dosing Weight=Ideal Body Weight (IBW) + (0.5 x (actual-IBW)).
(Note: Use Actual body weight if IBW is less than actual weight)

Ideal Body Weight (IBW) (**male**) = 50.0 kg + 2.3 kg (each inch > 5 feet)

Ideal Body Weight (IBW) (**female**) = 45.5 kg + 2.3 kg (each inch > 5 feet)