DIAGNOSTIC SERVICES MANITOBA
SERVICES DIAGNOSTIC MANITOBA

BBM Best Blood Manitoba

Patient Identifier:

Name: _____

PHN: _____

DOB: _____

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

FOLLOW UP

Evaluation must be completed every 6 months during treatment for patient to continue receiving IVIG.

Date of Completion: _____

Please answer the following questions regarding your patient regardless of intention to continue/discontinue treatment:

1. **Indication:** _____

2. Was the desired clinical outcome achieved? ☐ Yes ☐ No

Please document as follows as evidenced by:	**Pre-Treatment**	**Post-Treatment**
> Strength score		
> Skin manifestations (please rank mild, moderate, severe)		
> Creatinine Kinase		
> Prednisone dose		
> Other (ESR, CRP, etc.)		

3. Is the minimal effective dose of IVIG/SCIG being prescribed? ☐ Yes ☐ No
   If no, please explain: _____

4. Has a tapering schedule been attempted? ☐ Yes ☐ No
   If no, please explain: _____

5. Has an attempt been made to discontinue IVIG/SCIG with transfer to an alternative immunosuppressive? ☐ Yes ☐ No
   If no, please explain: _____

6. Please list current immunosuppressive treatment: a) _____
   b) _____

7. Were any complications associated with the IVIG therapy? ☐ Yes ☐ No
   ☐ Infusion related ☐ Headache ☐ Hemolytic reaction
   ☐ Thrombosis ☐ Other, please describe: _____

8. In case of ITP, has there been objective improvement in platelet count? ☐ Yes ☐ No

9. Have there been recurrent or serious infections? ☐ Yes ☐ No

10. Do you wish to continue IVIG treatment for this patient? ☐ Yes ☐ No
    If no, please explain: _____
    Dose: _____ Patient height: _____ Patient weight: _____
    If yes, also include the following documentation (**if applicable**)

11. **Patient's interim medical history since last request:**
    ☐ Updated lab results ☐ Updated consultation note outlining rationale for retreatment
    ☐ Creatinine Kinase ☐ Muscle Strength Assessment
    ☐ AST ☐ ALT ☐ Creatinine ☐ Other _____

Additional comments: Consulting Physician, if applicable _____

Required Physician signature: _____ Date: _____
(must be approved prescriber)

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

SAP #: 331891

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. Follow up treatment after the first 6 months of treatment and then every six months for multiple infusions.

The Physician or designate instructions for completion:

Note: Ordering Physician must be on the Approved Prescriber 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 the **Date of Completion**.
3. Identify the **Treating Physician**, their **Specialty** and, if a consult has occurred, the **Consulting Physician**.
4. Indicate if the form completion is due to **Changes to Treatment.**
5. If submitting 6 month F**ollow Up form** complete questions 1-11 as applicable.

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 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)