MOHLTC IG Request Form

For Neurology Use Only

Patient Name:	
Patient Hospital/Medical Record#:	
Patient DOB (YYYY/MM/DD):	
Gender M/F:	
Location:	
Ontario Health Insurance#:	

ALL FIELDS BELOW ARE MANDATORY

SECTION A: Physician & Hospital Information

Date of Request (YYYY/MM/DD)	Date Required (YYYY/MM/DD)	Hospital Transfusion Service (HTS) Fax Number
Name of Ordering Physician	Physician's Contact Phone Number	Physician's Email
Is the patient being seen by a Neurologist/ Neuromuscular Specialist? ☐ Yes ☐ No	Is the request for a hospital inpatient? ☐ Yes ☐ No	Hospital where patient will receive IG

SECTION B: Request Type

☐ Initial Request: Maximum 6 month approval	☐ Renewal Request: A reassessment should be done to confirm IG treatment continues to be effective and that minimum effective dose is being applied. Maximum 12 month approval.

SECTION C: Clinical Indication

Refer to Ontario IG Management Utilization Guidelines for additional indications where IG may be appropriate

ApprovedCondition	Guidelines for INITIAL Request	Guidelines for RENEWAL Request
☐ Guillain–Barré Syndrome (GBS) including Miller Fisher Syndrome and other variants	▪ IG recommended for Grade 3 severity (able to walk with aid) or greater; or less than Grade 3 severity that are progressing. ▪ IG should be given within 2 weeks of symptom onset. ▪ Adult: Total Dose of 2 g/kg divided over 2 to 5 days. ▪ Pediatric: Total Dose of 2 g/kg divided over 2 days.	▪ IG treatment for GBS is typically one-time/in the acute setting. ▪ Re-treatment for patients who do not respond may be considered. Repeat treatment with IVIG at 2g/kg divided over 2-5 days.
☐ Myasthenia Gravis (MG)	▪ IG is recommended as first-line treatment in moderate-severe MG or in myasthenic crisis. ▪ Induction Dose: 2g/kg divided over 2-5 days. ▪ Initial requests may be made for induction plus two maintenance doses; fill out Section D accordingly.	▪ IG in combinations with immunosuppressive therapy can be considered in refractory cases. If additional IG is required, dose should be adjusted depending upon response and titrated to the minimum effective dose. ▪ Maintenance Dose: 1g/kg
☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	▪ IG is recommended as first-line therapy in CIDP. ▪ Induction Dose: 2 g/kg divided over 2 to 5 days. ▪ All patients receiving IG for chronic treatment of CIDP should be followed by a neuromuscular specialist.	▪ Immunosuppressive therapy in combination with IG can be considered in refractory cases. Continued use should be based on objective measures of sustained effectiveness. Aim for minimum effective dose. ▪ Maintenance Dose: 1g/kg every3 weeks.
☐ Multifocal Motor Neuropathy (MMN)	▪ IG is recommended as first-line treatment for MMN. ▪ Induction Dose: 2g/kg divided over 2-5 days.	▪ Maintenance Dose: Tailor to the lowest dose that maintains clinical efficacy, usually 1g/kg or less per treatment course. Some patients may require higher doses for efficacy, up to 2g/kg every 4 weeks.

Other (please specify the diagnosis): ______________________________

These requests will require screening by Transfusion Service. Please include information regarding treatment to date and documentation to support IG treatment for an unapproved indication.

Has the patient used other therapies to treat this condition? ☐ Yes, specify other treatments below ☐ No

Treatment	Dose (if applicable)	Duration of treatment	What was the outcome?
			☐ No response ☐ Contraindications ☐ Intolerance
			☐ No response ☐ Contraindications ☐ Intolerance

Other Comments: (include notes regarding response to IG therapy)

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

☐ Intravenous IG (IVIG) ☐ Subcutaneous IG (SCIG)

Patient Weight: kg Patient Height: cm BMI: **Dose must be adjusted for BMI greater than or equal to 30**

Induction/One-time dose	g/kg = Total dose of g; divided over days
Maintenance dose	g/kg = Total dose of g; divided over days; every weeks; Duration: months

Dose Calculator Used? ☐ Yes ☐ No If No, why was it not used?

SECTION E: 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 or designate:	Date:

Please fax/send to :