Ontario

MOHLTC IVIG Request Form

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

Date Requested: (YYYY/MM/DD)	Date Required: (YYYY/MM/DD)
Patient weight: kg Patient height: cm	Treating Physician:
	Physician Specialty:

Indicate dosage required and duration of request

☐ Induction dose:_____g/kg =_____g total dose* _____ g per day X_____days ☐ Maintenance dose:_____g/kg =_____g total dose* _____ g per day X_____days, q_____weeks Duration of request:_____months (max 6 months - exception PID, max. 12, then new approval form required)	☐Dose calculator used. ☐Not required (Maintenance dose) ***Verification of dosage using Dose Calculator tool is recommended.** **Refer to** http://www.transfusionontario.org/dose/ IgG level/Platelet Count/other relevant test results. Result: Date:

Clinical Indication for use must be recorded below

Medical Condition	Suggested initial dose and duration
☐ Acute antibody mediated rejection	0.1 g/kg/treatment day or as a set dose of 2 g/kg total
☐ Dermatomyositis **As of May 30 2016: For Neurology indications please use the MOHLTC IGSP Request Form** http://transfusionontario.org/en/cmdownloads/categories/igsp-neurology/	Initial dose: Adult: Total dose of 2 g/kg divided over 2 to 5 days. Pediatric: Total dose of 2 g/kg divided over 2 days. Maintenance dose: A systematic approach should be taken to determine the minimum effective dose, and continued use of IVIG should be based on objective measures of its sustained effectiveness.
☐ Fetal/Neonatal Alloimmune Thrombocytopenia (F/NAIT)	Maternal dose: weekly 1 g/kg. Infant: an initial dose of 1 g/kg.
☐ 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 2 hours; if necessary repeat in 12 hours.
☐ Immune Thrombocytopenia Purpura (ITP) Adult ☐ Immune Thrombocytopenia Purpura (ITP) Pediatric	Adult: Acute ITP with bleeding or no response to steroids: 1 g/kg daily for 2 days. Chronic ITP Post splenectomy 0.5 g/kg every 4 weeks. Pediatric: One dose of 0.8 to 1 g/kg with a second dose given within 48 hours if the platelet count has not increased to >$20x10^9$/L.
☐ 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 Dermatomyositis (JD) initial treatment	Total dose of 2 g/kg divided over 2 days.
☐ Kawasaki Disease (KD) initial treatment	2 g/kg for 1 day.
☐ Kidney transplant from living donor(recipient de-sensitization)	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	1 g/kg daily for 2 days.
☐ 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 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. Document the patient height and weight.
3. Identify treating physician and their specialty e.g. Hematology, Dermatology etc.
4. Identify the total dose per treatment using the dose calculator.*
5. Record IVIG dose and duration of therapy.
6. Check the "Dose calculator used" box if dose was confirmed using the dose calculator. **
7. Check the appropriate box to indicate the clinical indication explaining the request (e.g. check box beside Chronic Inflammatory Demyelinating Polyneuropathy).
8. Check 'Other' if the clinical indication does not appear on the list; requests for 'Other' indications are subject to screening.
9. Document the platelet count in ITP, IgG level in PID and SID or other relevant test results as required.
10. 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.
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 overweight and obese patients.**
****Use of the dose calculator may not be applicable for maintenance therapy.**