Interior Health

Patient Name *(last)* _____

(first) _____

DOB *(dd/mmm/yyyy)* _____

PHN _____ MRN _____

Account/Visit # _____

IH USE ONLY

SECONDARY IMMUNODEFICIENCY - RENEWAL REQUEST - INTRAVENOUS IMMUNE GLOBULIN (IVIG)

Instructions:

1. Complete all sections below. ***The approval/release process will be deferred until required documentation is submitted.***
2. Submit for approval to IH IVIG Coordinators by **fax 250-862-4131**. If urgent, send form to hospital TM/LAB where patient will receive IVIG. All requests are screened per BC Immunoglobulin Utilization Management Program.
3. If **Initial Request** or recommencement of immunoglobulin therapy is required, complete SID IVIG Initial Form #826795.

1. Transfusion Location _____

☐ **I have prescribing privileges at this facility and I will write the prescription orders for IVIG transfusion.**

☐ **I do not have prescribing privileges and** *(physician name)* _____ **will co-sign transfusion orders.**

2. History of Infections since starting Immunoglobulin Therapy

Date	Type/Site	Hospital	Antibiotics	Cultures

3. Initial assessment of clinical effectiveness within first 6 months of immunoglobulin replacement therapy

☐ Initial review (6 months after initial approval) Date: _____

IgG _____ g/L IgM _____ g/L IgA _____ g/L

4. Annual assessment of clinical effectiveness of immunoglobulin replacement therapy (assessed by trough Ig levels)

☐ IgG _____ g/L IgM _____ g/L IgA _____ g/L Date: _____

Note: Upward trending or normal trough immunoglobulin levels are suggestive of immune system recovery. Immunologist/designated expert review to consider a trial cessation of immunoglobulin therapy is strongly recommended.

☐ Extend immunoglobulin replacement to April and start trial cessation period of immunoglobulin replacement therapy for the purposes of immunological evaluation in May. Duration of cessation period: _____

☐ Cessation of immunoglobulin replacement therapy contraindicated. **Indicate reason below.**

- ☐ Neutropenia – ANC less than 0.5
- ☐ Continued immune-suppressant medication. **Specify:** _____
- ☐ Active bronchiectasis **AND/OR** ☐ Suppurative lung disease
- ☐ Underlying condition persists without significant improvement **AND** initial qualifying criteria met
- ☐ Continuation of Ig replacement specifically recommended by immunologist/ designated expert.
  - ☐ Attach clinical consultation

5. Weight AND Height Weight: _____ kg Adjusted Body Weight (ABW) _____ kg

Height: _____ cm Dosing Calculator: www.pbco.ca

6. IVIG Dose ☐ 0.4 g/kg (ABW) **OR** ☐ total dose _____ g divided over _____ days

Frequency: ☐ monthly ☐ q4 weeks or ☐ every _____ days for _____ courses

7. Requesting Physician and Medical Services Plan number (MSP #): _____

Date (dd/mmm/yyyy)	Time (24 hour)	Physician Name	Signature	Initials	College ID #

8. Hematopathologist / Pathologist Screening Note ☐ **Approved** ☐ **Denied** ☐ **Deferred to expert**

Comment _____

Date (dd/mmm/yyyy)	Time (24 hour)	Printed Name	Signature	Initials	Designation / College ID #