Interior Health

Patient Name *(last)* _____

(first) _____

DOB *(dd/mmm/yyyy)* _____

PHN _____ MRN _____

Account/Visit # _____

IH USE ONLY

NEUROLOGY INTRAVENOUS IMMUNE GLOBULIN (IVIG) REQUEST

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.

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. Neurologic Diagnosis: ☐ Confirmed ☐ Probable / Possible

Peripheral Nervous System

Approved Conditions:

- ☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) (including multifocal and distal variants without paraprotein)
- ☐ Guillain-Barré syndrome (GBS), incl. Miller-Fisher syndrome
- ☐ Multifocal Motor Neuropathy (MMN)
- ☐ Myasthenia Gravis (MG)

Conditionally Approved Conditions:
(3 cycles approved at hospital site, followed by panel review)

- ☐ Atypical/Possible CIDP
- ☐ Paraproteinemic Neuropathy
- ☐ PNS Vasculitis/Mononeuritis Multiplex
- ☐ Sensory Ganglionopathy / Neuronopathy
- ☐ Lambert Eaton Syndrome
- ☐ Severe Plexopathy/Radiculoplexopathy
- ☐ Autoimmune Autonomic Neuropathy
- ☐ Paraneoplastic neuropathy
- ☐ Immune Mediated Neuromyotonia/Isaac's Syndrome
- ☐ Complex Regional Pain Syndrome

Screening will be performed by Provincial Rheumatology Panel:

- ☐ Immune Mediated Necrotizing Myopathy with/without HMGCR Myositis
- ☐ Inflammatory Myositis (Excluding Inclusion Body Myositis)

Only In Exceptional Circumstances:
(panel review always required before IVIg approval)

- ☐ Atypical Diabetic Neuropathy

Other condition not listed *(specify):*

_____

_____

Central Nervous System

Conditionally Approved Conditions:
(3 cycles approved at hospital site, followed by panel review)

- ☐ Neuromyelitis Optica Spectrum Disorder (NMOSD)
- ☐ MOG Antibody Disease (MOGAD)
- ☐ Acute disseminated encephalomyelitis (ADEM)
- ☐ Transverse Myelitis
- ☐ Optic Neuritis
- ☐ Stiff-person Spectrum Disorder (SPSD)
- ☐ Progressive Encephalitis with Rigidity and Myoclonus (PERM)
- ☐ Antibody Mediated Autoimmune Encephalitis (AMAE)
- ☐ Antibody Negative Autoimmune Encephalitis (ANAE)
- ☐ CNS Vasculitis
- ☐ Autoimmune Epilepsy
- ☐ New-Onset Refractory Status Epilepticus (NORSE)
- ☐ Febrile Infection-Related Epilepsy Syndrome (FIRES)
- ☐ Super Refractory Status Epilepticus
- ☐ Severe Disabling Drug-Resistant non-surgical Epilepsy
- ☐ Rasmussen Encephalitis
- ☐ Childhood epileptic encephalopathy
- ☐ Landau Kleffner syndrome
- ☐ Electrical Status Epilepticus in Sleep syndrome (ESES)
- ☐ PANDAS
- ☐ Opsoclonus Myoclonus
- ☐ Susac Syndrome

Only In Exceptional Circumstances:
(panel review always required before IVIg approval)

- ☐ Paraneoplastic Cerebellar Degeneration
- ☐ Lennox Gastaut Syndrome
- ☐ Atypical Rolandic Epilepsy
- ☐ West Syndrome
- ☐ Multiple Sclerosis

The following clinical indications are not indicated for use of Ig products. Any requests will be denied by Transfusion Medicine: Lupus Cerebritis, Myalgic Encephalomyelitis / Chronic Fatigue Syndrome, Autism, Adrenoleukodystophy, Tolosa Hunt, Amyotrophic Lateral Sclerosis, Critical Illness Polyneuropathy, Inclusion Body Myositis, and POEMS

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3. Weight AND Height

Weight: _____ kg

Height: _____ cm

Adjusted Body Weight (ABW) _____ kg

Dosing Calculator: www.pbco.ca

4. Induction Dose

☐ 0.4 g/kg (ABW) ☐ 1 g/kg (ABW) ☐ 2 g/kg (ABW) ☐ **Other** *(specify):* _____

Transfuse _____ grams IVIG every 24 hours × _____ day(s)

5. Maintenance Dose

☐ 0.4 g/kg (ABW) ☐ 1 g/kg (ABW) ☐ 2 g/kg (ABW) ☐ **Other** *(specify):* _____

Transfuse _____ grams IVIG every 24 hours × _____ day(s)

Frequency: ☐ monthly ☐ q4 weeks ☐ every _____ days for ☐ 6 courses ☐ other

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

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

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

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