Interior Health

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

Patient Name *(last)* ______
(first) ______
DOB *(dd / mmm / yyyy)* ______
PHN ______ MRN ______
Account / Visit # ______
IH USE ONLY

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 **Renewal Request**, complete SID IVIG Renewal Form #826796

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. Underlying conditions

- ☐ Chronic Lymphocytic Leukemia
- ☐ Memory B cell Deficiency Secondary to hematopoietic stem cell transplantation
- ☐ Multiple Myeloma
- ☐ Non-Hodgkin Lymphoma
- ☐ Other *(specify)*: ______

3. Required Baseline Results and Infection History (within 6 months)

- ☐ Baseline IgG ______ g / L IgM ______ g / L IgA ______ g / L Date: ______
- ☐ Second IgG (suggest testing at 4-6 weeks post active infection): IgG ______ g / L Date: ______
- ☐ Bronchiectasis
- ☐ Sino-pulmonary infection
- ☐ Recurrent bacterial infections
- ☐ Bacterial Infections, other *(specify)*: ______

4. I confirm

- ☐ Results of serum IgG measured on two separate occasions
- ☐ Significant hypogammaglobulinemia with serum IgG less than 5 g / L (excluding paraprotein)
- ☐ Exclusion of a pre-existing primary immunodeficiency (see Primary Immunodeficiency diagnostic algorithm: https://pbco.ca/index.php/programs/immunodeficiency/primary-immunodeficiency)

AND Option 1 or 2

- ☐ **OPTION 1:** Referral to an immunologist or equivalent subspecialist with clinical expertise/ experience in management of SID patients
- ☐ **OPTION 2:**
  - ☐ Infections unrelated to chemotherapy / radiotherapy including neutropenia or mucosal / epithelial toxicity **AND**
  - ☐ Infections confirmed due to encapsulated bacteria or clinically consistent with encapsulated bacteria (e.g. Streptococcus pneumoniae, Haemophilus influenzae, and Neisseria meningitidis) **AND**
  - ☐ At least one life threatening bacterial infection in the last 12 months, (e.g. ICU admission) **OR**
  - ☐ At least 2 serious bacterial infections in the last 6 months requiring more than standard courses of antibiotics (e.g. hospitalization, intravenous or prolonged antibiotic therapy)

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 ☐ every ____ days for ☐ 6 courses ☐ other ______

7. 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	Initials	Designation / College ID #