

Patient Identifier:

Name: _____

PHN: _____

DOB: _____

**Intravenous Immune Globulin (IVIG)
Subcutaneous Immune Globulin (SCIG) Physician
Request Form**

FOLLOW UP

Evaluation must be completed every 6 months during treatment for patient to continue receiving IVIG.

Date of Completion: _____

Please answer the following questions regarding your patient regardless of intention to continue/discontinue treatment:

1. **Indication:** _____
2. Was the desired clinical outcome achieved? Yes No
Please document as follows as evidenced by:

	Pre-Treatment	Post-Treatment
> Strength score	_____	_____
> Skin manifestations (please rank mild, moderate, severe)	_____	_____
> Creatinine Kinase	_____	_____
> Prednisone dose	_____	_____
> Other (ESR, CRP, etc.)	_____	_____
3. Is the minimal effective dose of IVIG/SCIG being prescribed? Yes No
If no, please explain: _____
4. Has a tapering schedule been attempted? Yes No
If no, please explain: _____
5. Has an attempt been made to discontinue IVIG/SCIG with transfer to an alternative immunosuppressive? Yes No
If no, please explain: _____
6. Please list current immunosuppressive treatment: a) _____
b) _____
7. Were any complications associated with the IVIG therapy? Yes No
 Infusion related Headache Hemolytic reaction
 Thrombosis Other, please describe: _____
8. In case of ITP, has there been objective improvement in platelet count? Yes No
9. Have there been recurrent or serious infections? Yes No
10. Do you wish to continue IVIG treatment for this patient? Yes No
If no, please explain: _____
Dose: _____ Patient height: _____ Patient weight: _____
If yes, also include the following documentation (if applicable)
11. **Patient's interim medical history since last request:**
 Updated lab results Updated consultation note outlining rationale for retreatment
 Creatinine Kinase Muscle Strength Assessment
 AST ALT Creatinine Other _____

Additional comments: _____ Consulting Physician, if applicable _____

Required Physician signature: _____ Date: _____
(must be approved prescriber)

All requested information must be provided. The issue of product will not occur until completed form is received

SAP #: 331891

Completion of Intravenous Immune Globulin (IVIG) and Subcutaneous Immune Globulin (SCIG) Physician Request Form

This form shall accompany a Request to Release form and is required for:

1. Follow up treatment after the first 6 months of treatment and then every six months for multiple infusions.

The Physician or designate instructions for completion:

Note: Ordering Physician must be on the Approved Prescriber which can be found on the Best Blood Manitoba website at <http://bestbloodmanitoba.ca/for-clinicians/>

1. Addressograph or use patient identification sticker.
2. Complete the **Date of Completion**.
3. Identify the **Treating Physician**, their **Specialty** and, if a consult has occurred, the **Consulting Physician**.
4. Indicate if the form completion is due to **Changes to Treatment**.
5. If submitting 6 month **Follow Up form** complete questions 1-11 as applicable.

Blood Bank Instructions:

1. Verify the **Ordering Physician** is on approved list of prescribers and all information is complete.
2. Return to sender if information is missing along with Request to Release form.
3. Add patient name, PHIN, physician and date to the IVIG site specific patient log.
4. Keep copy of form in blood bank.
5. Fax Form to Blood Management Service, 204-940-3255.

Dosing Guidelines:

Dosing Weight is an adjusted body weight of obese or overweight patients used to calculate the dose of drugs for which there are recommendations specifying that the actual body weight should be adjusted for use in the dose calculations.

Dosing Weight=Ideal Body Weight (IBW) + (0.5 x (actual-IBW)).
(Note: Use Actual body weight if IBW is less than actual weight)

Ideal Body Weight (IBW) (**male**) = 50.0 kg + 2.3 kg (each inch > 5 feet)

Ideal Body Weight (IBW) (**female**) = 45.5 kg + 2.3 kg (each inch > 5 feet)