BLOOD TRANSFUSION SERVICE
Provincial Clinical Laboratory

Queen Elizabeth Hospital
Charlottetown, PEI
Phone (902) 894-2300
Fax (902) 894-2415

Prince County Hospital
Summerside, PEI
Phone (902) 438-4280
Fax (902) 438-4281

Address for Non-PEI Residents Required

Name: _____

Street: _____ Place Label Here

City: _____ Prov./State _____

Postal Code/Zip: _____

REQUEST FOR IVIG – DERMATOLOGY (Adult and Pediatric)

Items preceded by a **bullet** (•) are active orders. Items preceded by a **checkbox** (□) are only to be carried out if checked

- **Any change to indication, dose, duration or frequency requires a new order**

Note: IVIG dose is calculated using the patient's DOSING BODY WEIGHT (DBW) for all indications. To obtain the DBW calculator, refer to http://novascotia.ca/dhw/nspbcp/

Patient Name:	MRN:	Allergies:
• Patient's Actual Weight (kg):	• Patient Height (cm):	• Gender:
IgA Deficient Product Required: ☐ Yes ☐ No	Is this a Repeat Dose due to lack of Expected Response? ☐ Yes ☐ No	Intended Treatment Start Date (dd/mm/yyyy):
• Infuse ____ g/kg = ____ g X ____ days. If indicated, repeat this regiment q ____ days for a total of ____ treatments		

Indicated Conditions	Prerequisites – Checkboxes must be checked/completed as appropriate. Missing information will result in delays or denial of product PATIENT MUST MEET THE FOLLOWING:	Dose
☐ **Scleromyxedema**	☐ Failed to respond or contraindications to corticosteroids	0.4 g/kg/d for 5 consecutive days q 4 weeks
☐ **Systemic Vasculitic Syndromes**	☐ Order must be in consultation with a Dermatologist Name: _____	2 g/kg q 4 weeks
☐ **Kawasaki Syndrome*** **PEDIATRIC ONLY**	No criteria are required other than a diagnosis	2 g/kg given once. If failure to respond, a 2nd dose may be given 24hrs later

Possibly Indicated Conditions are approved for a 3 month period only at which time a clinical outcome questionnaire must be provided for the patient to continue treatment

Possibly Indicated Conditions	Prerequisites – Checkboxes must be completed PATIENT MUST MEET THE FOLLOWING:	Dose
☐ **Chronic Idiopathic Urticaria**	☐ Failed to respond or contraindications to high dose antihistamines ***AND*** ☐ Failed to respond or contraindications to Xolair® (if covered)	**Induction:** 1 g/kg/d for 3 d **Maintenance:** 1 g/kg q 4 w
☐ **Dermatomyositis***	☐ Significant muscle weakness ***AND*** ☐ Failed to respond or contraindications to corticosteroids	2 g/kg divided over 2-5 d
☐ **Necrobiotic Xanthogranuloma**	☐ Failed to respond or contraindications to corticosteroids	2 g/kg q 4 weeks
☐ **Pre-Tibial Myxedema**	☐ Failed to respond or contraindications to intralesional and oral steroids	2 g/kg q 4 weeks
☐ **Pyoderma Gangrenosum**	☐ Cared for in consultation with a Dermatologist Name: _____ ***AND*** ☐ Failed to respond or contraindications to systemic steroids	2 g/kg q 4 weeks
☐ **Severe Forms of Autoimmune Blistering Diseases**	☐ Disease is rapidly progressing **AND** ☐ Failed to respond or contraindications to systemic steroids	2 g/kg q 4 weeks
☐ **Severe Lupus Erythematosus**	☐ Failed to respond or contraindications to corticosteroids	2 g/kg q 4 weeks
☐ **Pediatric Atopic Dermatitis** **PEDIATRIC ONLY**	☐ Failed to respond or contraindications to topical steroids and calcineurin inhibitors	2 g/kg q 4 weeks

PHYSICIAN'S NAME (PRINT):	**CONTACT PHONE #/REG NO.**
PHYSICIAN'S SIGNATURE:	**DATE:**

*May be considered URGENT if notified by ordering physician

Bar Code
LAB USE ONLY

Original – Chart