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 – NEUROLOGY (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**
☐ **Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)** **ADULT ONLY**	☐ Order must be in consultation with a Neurologist Name: _____	2 g/kg divided over 2-5 days **Maintenance:** 1 g/kg q 2-6 weeks
☐ **Multifocal Motor Neuropathy (MMN)** **ADULT ONLY**	No criteria are required other than a diagnosis of MMN	2 g/kg divided over 2-5 days **Maintenance:** 1 g/kg q 2-6 weeks
☐ **Guillain-Barré Syndrome***	☐ IVIG is being given within 2 weeks of symptom onset ***AND*** ☐ Hughes Disability score of 3 or more or less than 3 with symptoms progressing	2 g/kg divided over 2-5 days
☐ **Myasthenia Gravis (MG)***	☐ Acute exacerbation (myasthenic crisis) ***OR*** ☐ Optimization prior to surgery and/or thymectomy ***OR*** ☐ Maintenance for moderate to severe MG in combination with immunosuppressive agents May be considered urgent if patient is ventilated	2 g/kg divided over 2-5 days q 4-6 weeks

*May be considered URGENT if notified by ordering physician

SEE REVERSE FOR POSSIBLY INDICATED CONDITIONS

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

Bar Code
LAB USE ONLY

Original – Chart

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REQUEST FOR IVIG – NEUROLOGY (Adult and Pediatric)

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Patient:	Allergies:	Gender:

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
☐ **Autoimmune Optic Neuropathy ADULT ONLY**	☐ Failed or contraindications to steroids	2 g/kg divided over 2-5 day
☐ **Lambert-Eaton Myasthenic Syndrome (LEMS) ADULT ONLY**	☐ Order must be in consultation with a Neurologist Name:_____	**Induction:** 2 g/kg divided over 2-5 days **Maintenance:** 0.4-1 g/kg q 2-6 w
☐ **Multiple Sclerosis (MS) Relapsing/Remitting Only ADULT ONLY**	☐ Pregnant/immediate post-partum period when other immunomodulation is contraindicated ***OR*** ☐ Relapsing/remitting MS who fail or have contraindications to standard immunomodulatory therapies	1 g/kg monthly with or without a 5 day induction of 0.4 g/kg daily
☐ **Neuromyelitis Optica (NMO) ADULT ONLY**	☐ Failed or contraindications to plasma exchange and/or steroids	1-2 g/kg in 2-5 divided doses
☐ **Paraneoplastic Cerebellar Degeneration ADULT ONLY**	☐ Within 1 month of symptom onset ***AND*** ☐ In conjunction with chemotherapy treatment	2 g/kg every 4-6 weeks
☐ **Stiff Person Syndrome ADULT ONLY**	☐ Failed or contraindications to GABAergic medications	2 g/kg divided over 2-5 days every 4-6 weeks
☐ **Autoimmune Encephalitis: N-Methyl-D-Asparate (NMDA)**	☐ Cared for in consultation with a Neurologist Name:_____ ***AND*** ☐ Used in conjunction with immunosuppressives and/or plasmapheresis	**ADULT:** 2 g/kg divided over 2-5 days **PEDIATRIC:** 1 g/kg daily for 2 days
☐ **Autoimmune Encephalitis: Rasmussen's Encephalitis***	☐ Short term, temporizing measure	**ADULT:** 2 g/kg divided over 2-5 days **PEDIATRIC:** 2 g/kg daily for 2 days
☐ **Acute Disseminated Encephalomyelitis (ADEM)* PEDIATRIC ONLY**	☐ Failed to respond or has contraindications to corticosteroids	1 g/kg daily for 2 days q 4-6 weeks
☐ **Post-streptococcal Autoimmune Disorders (PANDAS and Sydenham's Chorea) PEDIATRIC ONLY**	☐ Order must be in consultation with a Pediatric Neurologist Name:_____	1 g/kg daily for 2 days

*May be considered URGENT if notified by ordering physician

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