Health PEI

BLOOD TRANSFUSION SERVICE 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: _____

Allergies: _____

ORDER SET
Intravenous Immunoglobulin (IVIG) Dermatology – Adult and Pediatric

Patient Name: _____ Patient MRN: _____ DOB: YYYY/MON/DD

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. **If** patient height **under 152.4 cm,** Dosing Body Weight equals Actual Weight. **If** patient height **over 152.4 cm,** use the DBW Calculator to obtain a clinically appropriate Dosing Body Weight. To obtain the DBW calculator, search "NS Health IVIG Dose Calculator" in an internet search engine.

Actual Weight (kg):	Height (cm):	Gender:
Dosing Body Weight (kg – see note above):	IVIG Rounded Dose (g):	

IgA Deficient Product Required: ❑ Yes ❑ No	Is this a repeat dose due to lack of expected response? ❑ Yes ❑ No	Intended Treatment Start Date (YYYY/MON/DD):

- Infuse _____ g/kg = _____ g daily for _____ days ***OR*** Infuse _____ g/kg = _____ g divided over _____ days
- If indicated, repeat this regimen every _____ 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/day for 5 consecutive days every 4 weeks
❑ **Systemic Vasculitic Syndromes**	❑ Order must be in consultation with a Dermatologist Name: _____	2 g/kg every 4 weeks

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® or equivalent (if covered)	**Induction:** 1 g/kg/day for 3 days **Maintenance:** 1 g/kg every 4 weeks
❑ **Dermatomyositis* ADULTS ONLY**	❑ Significant muscle weakness ***AND*** ❑ Failed to respond or contraindications to corticosteroids ❑ Prescribed by Dermatologist Name: _____	2 g/kg divided over 2 to 5 days
❑ **Necrobiotic Xanthogranuloma**	❑ Failed to respond or contraindications to corticosteroids	2 g/kg every 4 weeks
❑ **Pyoderma Gangrenosum**	❑ Cared for in consultation with a Dermatologist Name: _____ ***AND*** ❑ Failed to respond or contraindications to systemic steroids	2 g/kg every 4 weeks
❑ **Severe Forms of Autoimmune Blistering Diseases**	❑ Disease is rapidly progressing ***AND*** ❑ Failed to respond or contraindications to systemic steroids ❑ Prescribed by Dermatologist Name: _____	2 g/kg every 4 weeks
❑ **Severe Lupus Erythematosus**	❑ Failed to respond or contraindications to corticosteroids	2 g/kg every 4 weeks
❑ **Pediatric Atopic Dermatitis PEDIATRIC ONLY**	❑ Treatment is at the direction of a Dermatologist ***AND*** ❑ Failed to respond or contraindications to topical steroids and calcineurin inhibitors	2 g/kg every 4 weeks

*** May be considered URGENT if notified by ordering prescriber**

Authorized Prescriber's Signature: _____ Reg. No.: _____

Prescriber's Name: _____ Date (YYYY/MON/DD): _____ Time: _____
Print