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) Hematology − Adult

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 or pre−pregnancy 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):	Pre−pregnancy Weight (kg − if applicable):	Height (cm):
Dosing Body Weight (kg − see note above):	IVIG Rounded Dose (g):	Gender:

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):

Dosage and Duration of Therapy

- 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
❑ **Immune Thrombocytopenia (ITP)***	❑ Major bleeding and platelets less than $50x10^9$/L ***OR*** ❑ Failed to respond to steroids after 3 or more days ***OR*** ❑ To produce an increase in platelet count to a level considered safe	**Acute:** 1 g/kg/day for 1 or 2 consecutive days depending on response **Chronic:** 1 to 2 g/kg no more frequently than every 2 weeks
❑ **Pregnancy − Associated ITP***	❑ There is major bleeding ***OR*** ❑ Platelet counts fall below $10x10^9$/L anytime during pregnancy ***OR*** 10 to $30x10^9$/L during second or third trimester ***OR*** ❑ Rapid elevation of platelets required before delivery or any invasive procedure (e.g. amniocentesis)	1 g/kg/day x 2 consecutive days (dosing body weight is based on the pre−pregnancy weight for determining IVIG dose) (no maximum dose)
❑ **Post−Transfusion Purpura (PTP)***	No prerequisites are required	1 g/kg repeated if necessary
❑ **Fetal Alloimmune Thrombocytopenia (FAIT)***	❑ Mother has been found to have anti−platelet alloantibodies through a prior affected pregnancy or close family member (e.g. sister) with an affected pregnancy ***AND*** ❑ Treatment is under the direction of a maternal fetal medicine centre	1 to 2 g/kg/week throughout the pregnancy (dosing body weight is based on the pre−pregnancy weight for determining IVIG dose; disease severity also considered) (no maximum dose)

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

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

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

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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**
❑ **Acquired Hemophilia with Factor VIII Inhibitor***	❑ Order must be in consultation with a Hematologist Name: _____	2 g/kg divided over 2 to 5 days
❑ **Factor XIII Inhibitor***	❑ Order must be in consultation with a Hematologist Name: _____	2 g/kg divided over 2 to 5 days
❑ **Secondary Immune Deficiency (SID)**	❑ Order must be in consultation with a Hematologist Name: _____	0.4 g/kg every 3 to 4 weeks
❑ **Warm Autoimmune Hemolytic Anemia**	Resistant to steroids and symptomatic anemia	Up to 2 g/kg
❑ **Hemophagocytic Lymphohistiocytosis (HLH)***	❑ Order must be in consultation with a Rheumatologist, Hematologist or General Internist Name: _____	2 g/kg divided over 2 to 5 days

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

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