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 − Pediatric (less than 18 years of age)

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
❑ **Post CAR−T cell therapy***	❑ Order must be in consultation with a Pediatric Hematologist Name: ______________________	0.4 to 0.6 g/kg every 3 to 4 weeks
❑ **Neonatal Alloimmune Thrombocytopenia (NAIT)***	❑ Treatment includes consultation with or is within a high−risk neonatal centre	1 g/kg/day x 2 consecutive days
❑ **Hemolytic Disease of the Newborn (HDN)***	❑ Total serum bilirubin (TSB) rising despite intensive phototherapy	0.5 to 1 g/kg with repeat dosing every 12 to 24 h prn
❑ **Immune Thrombocytopenia (ITP)***	❑ Platelets less than $50x10^9$/L ***AND*** either the presence of major bleeding or surgery required ***OR*** ❑ Platelets less than $20x10^9$/L ***AND*** treatment clinically indicated	0.8 to 1 g/kg Repeat if platelet count has not increased to above $20x10^9$/L after 24 to 48 h
❑ **Neonates of Mothers with ITP***	❑ Platelets less than $50x10^9$/L ***OR*** ❑ Imaging evidence of intracranial hemorrhage or other serious bleeding	1 g/kg/day x 2 consecutive days Repeat if platelet count is still less than $30x10^9$/L after 24 h

Possibly indicated conditions are approved for a 3 month period <u>only</u>, 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
❑ **Hematological Malignancy***	❑ Acquired hypogammaglobulinemia ***PLUS*** ❑ History of severe invasive or recurrent sino pulmonary infections ***OR*** ❑ Registered on a protocol which requires IVIG support	0.4 to 0.6 g/kg every 3 to 4 weeks
❑ **Secondary Immune Deficiency (SID)***	❑ Order must be in consultation with a Pediatric Hematologist Name: ______________________	0.4 g/kg every 3 to 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