Health PEI
BLOOD TRANSFUSION SERVICE LABORATORY

Queen Elizabeth Hospital
Charlottetown, PEI
Phone (902) 894-2300
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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) Immunology − Adult and 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
❑ **Inborn Errors of Immunity (IEI) also known as Primary Immunodeficiency (PID)***	❑ Order must be in consultation with an Immunologist; Hematologists, General Internists or Infectious Disease Specialists may also consult for ADULT ONLY patients Name: _____ ***AND*** ❑ IgG levels done within the last 3 to 6 months Level: _____ g/L Date (YYYY/MON/DD): _____ Target: 7 to 10 g/L for most patients May be considered urgent if acute / severe infection	**ADULT and PEDIATRIC:** 0.4 to 0.7 g/kg every 3 to 4 weeks
❑ **Secondary Immunodeficiency (SID)***	❑ Recent life−threatening or recurrent clinically significant infection(s) related to low levels of polyclonal immunoglobulin May be considered urgent if acute / severe infection	**ADULT and PEDIATRIC:** 0.4 to 0.7 g/kg every 3 to 4 weeks
❑ **Other:** _____ **(Indication and dosing to be approved by the Adult or Pediatric Immunology Clinical Expert)**	❑ Order must be in consultation with an Immunologist Name: _____	

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 ADULT ONLY**	❑ Has failed to respond or has contraindications to high dose antihistamines ***AND*** ❑ Failed to respond or has contraindications to Xolair® or equivalent (if covered)	**Induction:** 1 g/kg/day for 3 days **Maintenance:** 1 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