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) Neurology − 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
❑ **Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) ADULT ONLY**	❑ Order must be in consultation with a Neurologist Name: _____	2 g/kg divided over 2 to 5 days **Maintenance:** 1 g/kg every 2 to 6 weeks
❑ **Multifocal Motor Neuropathy (MMN) ADULT ONLY**	No criteria are required other than a diagnosis of MMN	2 g/kg divided over 2 to 5 days **Maintenance:** 1 g/kg every 2 to 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 to 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	2 g/kg divided over 2 to 5 days every 4 to 6 weeks

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

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

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

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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**
❑ **Autoimmune Optic Neuropathy ADULT ONLY**	❑ Failed or contraindications to steroids	2 g/kg divided over 2 to 5 days
❑ **Lambert−Eaton Myasthenic Syndrome (LEMS) ADULT ONLY**	❑ Order must be in consultation with a Neurologist Name: _____	**Induction:** 2 g/kg divided over 2 to 5 days **Maintenance:** 0.4 to 1 g/kg every 2 to 6 weeks
❑ **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 to 2 g/kg in 2 to 5 divided doses
❑ **Anti−myelin oligodendrocyte glycoprotein (Anti−MOG) syndromes ADULT ONLY**	❑ Patient has failed or has contraindications to immunosuppressive therapy	2 g/kg in 2 to 5 divided doses **Maintenance:** 1 g/kg every 2 to 6 weeks
❑ **Paraneoplastic Cerebellar Degeneration ADULT ONLY**	❑ Within 1 month of symptom onset ***AND*** ❑ In conjunction with chemotherapy treatment	2 g/kg every 4 to 6 weeks
❑ **Stiff Person Syndrome ADULT ONLY**	❑ Failed or contraindications to GABAergic medications	2 g/kg divided over 2 to 5 days every 4 to 6 weeks
❑ **Autoimmune Encephalitis: N−Methyl−D−Aspartate (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 to 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 to 5 days **PEDIATRIC:** 2 g/kg daily for 2 days
❑ **Acute Disseminated Encephalomyelitis (ADEM)* PEDIATRIC ONLY**	❑ Failed to respond to or has contraindications to corticosteroids	1 g/kg daily for 2 days every 4 to 6 weeks
❑ **Post−streptococcal Autoimmune Disorders (PANDAS, PANS and Sydenham's Chorea) PEDIATRIC ONLY**	❑ Order must be in consultation with a Pediatric Neurologist Name: _____	1 to 2 g/kg per month

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

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