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) Rheumatology − 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
❑ **Immune−Mediated Inflammatory Myositis* ADULT ONLY**	❑ Failed to respond to or contraindications to corticosteroids ***OR*** ❑ Presence of life−threatening disease	2 g/kg divided over 2 to 5 days every 4 to 6 weeks. Taper when disease stable.
❑ **Juvenile Dermatomyositis* PEDIATRIC ONLY**	❑ Glucocorticoids and other 2nd line agents are contraindicated ***OR*** IVIG is part of early therapy in a critically ill child ***AND*** ❑ Order must be in consultation with a Pediatric Rheumatologist Name: ______________________	2 g/kg every 2 to 4 weeks
❑ **Kawasaki Syndrome* PEDIATRIC ONLY**	No criteria are required other than a diagnosis of Kawasaki Syndrome	2 g/kg given once. If failure to respond, a 2nd dose may be given at least 24 hours later
❑ **Systemic Onset Juvenile Idiopathic Arthritis* PEDIATRIC ONLY**	❑ Is resistant to other forms of therapy ***AND*** ❑ Order must be in consultation with a Pediatric Rheumatologist Name: ______________________	1 to 2 g/kg every 2 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

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The following indications are approved for one treatment. If additional treatments are requested, a clinical outcome questionnaire must be provided to the appropriate clinical expert for consultation.

Conditions	Prerequisites − checkboxes must be completed	Dose
❑ **Catastrophic Antiphospholipid Antibody Syndrome*** **ADULT ONLY**	❑ Order must be in consultation with a Rheumatologist or a Hematologist. Name: ______________	2 g/kg divided over 2 to 5 days
❑ **Adult−onset Still's Disease** **ADULT ONLY**	❑ Order must be in consultation with a Rheumatologist Name: ______________	2 g/kg divided over 2 to 5 days
❑ **Sjogren's Syndrome** **ADULT ONLY**	❑ Order must be in consultation with a Rheumatologist Name: ______________	2 g/kg divided over 2 to 5 days
❑ **Hematophagocytic Lymphohistiocytosis*** **ADULT ONLY**	❑ Order must be in consultation with a Rheumatologist, Hematologist or General Internist Name: ______________	2 g/kg divided over 2 to 5 days
❑ **Multisystem Inflammatory Syndrome (MIS)*** **ADULT and PEDIATRIC**	❑ Cared for in consultation with a Rheumatologist Name: ______________	2 g/kg over 1 to 2 days
❑ **Hemophagocytic Lymphohistiocytosis / Macrophage Activation Syndrome (HLH / MAS)*** **PEDIATRIC ONLY**	❑ Cared for in consultation with a Pediatric Rheumatologist, Pediatric Hematologist or Pediatric Immunologist Name: ______________	2 g/kg given once

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Authorized Prescriber's Signature: ______________________ Reg. No.: ______________

Prescriber's Name: ______________________ Date (YYYY/MON/DD): ______________ Time: __________
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