Health PEI
BLOOD TRANSFUSION SERVICE LABORATORY

Queen Elizabeth Hospital
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Address for Non-PEI Residents Required
Name: _____
Street: _____ **Place Label Here**
City: _____ Prov./State _____
Postal Code/Zip: _____
Allergies: _____

ORDER SET
Intravenous Immunoglobulin (IVIG) Solid Organ Transplant − 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
❑ **Acute Antibody Mediated Rejection***	Pathology proven acute antibody mediated rejection	0.2 g/kg after each plasmapheresis session up to a total of 10 doses (i.e. 2 g/kg maximum cumulative dose), then reassess (Additional doses may be required depending on response)

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 Parvovirus Infection with Anemia**	❑ Immunocompromised patient with parvovirus B19 causing Pure Red Cell Aplasia	**Initial:** 0.4 to 1 g/kg for 5 to 10 days **Maintenance**: 0.4 g/kg every 4 weeks
❑ **BK Polyomavirus (BKV)***	❑ Immunocompromised patient with a pathological diagnosis of BK polyomavirus	0.2 g/kg/week for 5 doses (i.e. 1 g/kg maximum cumulative dose), then reassess (Additional doses may be required depending on response)

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

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

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