

Patient Name:
Patient Hospital/Medical Record#:
Patient DOB (YYYY/MM/DD):
Gender M/F:
Location:
Ontario Health Insurance#:

ALL FIELDS BELOW ARE MANDATORY

SECTION	۸.	Physician	Q.	Hospital	Informat	ion
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SECTION A: Physicia	an & Hospital Informat	tion				
Date of Request (YYYY/MI	Date Required (YYYY/	Date Required (YYYY/MM/DD)		Hospital Transfusion Service (HTS) Fax Number		
Name of Ordering Physicia	Physician's Contact Ph	Physician's Contact Phone Number		Physician's Email		
Is the patient being seen by Specialist? ☐ Yes ☐ No	Is the request for a ho	Is the request for a hospital inpatient? ☐ Yes ☐ No		Hospital where patient will receive IG		
SECTION B: Request	Туре					
☐ Initial Request: Max		Renewal Request: A reassessment should be done to confirm IG treatment continues to be effective and minimum effective dose is being applied. Maximum 12 month approval.				
SECTION C: Clinical	Indication R	efer to Ontario IG Manager	ment Utiliz	ation Guideline	s for additional indications where IG may be appropriate	
ApprovedCondition	Guidelines f	or INITIAL Request			Guidelines for RENEWAL Request	
☐ Guillain—Barré Syndrome (GBS) including Miller Fisher Syndrome and other variants ☐ IG recommended for Grade 3 severity (able to walk w greater; or less than Grade 3 severity that are progress IG should be given within 2 weeks of symptom onset. Adult: Total Dose of 2 g/kg divided over 2 to 5 days. Pediatric: Total Dose of 2 g/kg divided over 2 days.				 IG treatment for GBS is typically one-time/in the acute setting. Re-treatment for patients who do not respond may be considered. Repeat treatment with IVIG at 2g/kg divided over 2-5 days. 		
☐ Myasthenia Gravis (MG)	te treatment in moderate-seve over 2-5 days. for induction plus two ction D accordingly.		 IG in combinations with immunosuppressive therapy can be considered in refractory cases. If additional IG is required, dose should be adjusted depending upon response and titrated to the minimum effective dose. Maintenance Dose: 1g/kg 			
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	g Induction Dose: 2 g/kg divided over 2 to 5 days.			 Immunosuppressive therapy in combination with IG can be considered in refractory cases. Continued use should be based on objective measures of sustained effectiveness. Aim for minimum effective dose. Maintenance Dose: 1g/kg every3 weeks. 		
Multifocal Motor Neuropathy (MMN)	■ IG is recommended as first-line treatment for MMN. ■ Induction Dose: 2g/kg divided over 2-5 days.			Maintenance Dose: Tailor to the lowest dose that maintains clinical efficacy, usually 1g/kg or less per treatment course. Some patients may require higher doses for efficacy, up to 2g/kg every 4 weeks.		
Other (please specify the diagnosis):						
Has the patient used ot	her therapies to treat this co	ondition? 🛮 Yes, specif	y other tr	eatments belo	ow □ No	
Treatment Dose (if applicat		icable)	le) Duration		What was the outcome?	
					☐ No response ☐ Contraindications ☐ Intolerance	
☐ No response ☐ Contraindications ☐ Intolerance						
Other Comments: (include r	notes regarding response to IG t	:herapy)				
SECTION D: Dosage	Information (Verification	of dose using Dose Calcula	ator tool is	recommended	. Refer to http://ivig.transfusionontario.org/dose/	
Introveneus IC (IV/IC)						

☐ Intravenous IG (IVIG)	☐ Subcutaneous IG (SCIG)					
Patient Weight:	kg Patient Height:	cm BMI:	Dose must	be adjusted for BMI greater	than or equal to 30	
Induction/One-time dose	g/kg = Total dose of	g; divided over	days			
Maintenance dose	g/kg = Total dose of	g; divided over	days; every	weeks; Duration:	months	
Dose Calculator Used?						

SECTION E: For Transfusion Medicine Use Only

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☐ Dose verified	☐ Dose adjusted to:	By (signature req'd):	
☐ Confirmed with ordering physician		Date:	
☐ Approved	☐ Denied		
Signature of Approving Phy	sician or designate:		Date: