fraserhealth **BC Provincial Blood Coordinating Office**

Regional Pre-Printed Orders for Immune Globulin (Ig) Therapy for Secondary Immunodeficiency (SID) – RENEWAL Request

Form ID: DRDO107673A New: November 16, 2022 Page: 1 of 1

DRUG & FOOD ALLERGIES

- **Mandatory** ☐ **Optional: Prescriber check (✓) to initiate, cross out and initial any orders not indicated.**

- Weight _____kg Height _____cm

INSTRUCTIONS:

- If this is for a new request, complete Regional Pre-Printed Orders for Immune Globulin (Ig) Therapy for Secondary Immunodeficiency (SID) – New Request (DRDO107672). (All Ig requests are screened in accordance with the BC Immune Globulin Utilization Management Program).

PRODUCT:

☐ Intravenous Immune Globulin (IVIg)
☐ Subcutaneous Immune Globulin (SCIg)

HISTORY:

- Complete history of infection since starting Ig Therapy using the table below:

History of Infections since starting Ig Therapy			
Date	Type/Site	Antibiotics	Cultures

- If additional documentation is needed, complete consult notes and fax along with this pre-printed order (PPO)

LABORATORY:

Immunologist/designated expert review is strongly recommended for a trial of Ig cessation if immune recovery is suggested by trending upward or normal IgM/IgA levels or IgG trough levels above lower limit of normal range for age.

- Trough levels: ☐ Initial (6 months after 1st approval) ☐ Annual ☐ Post-Cessation
- Last trough result: _____ (date)
  - IgG g/L _____ IgM g/L _____ IgA g/L_____

IVIg DOSE REQUEST:

- Dose: ☐ 0.4 g/kg ☐ 0.5 g/kg ☐ 0.6 g/kg ☐ Total dose ___ g over ___days
- Frequency: ☐ Monthly ☐ Q4Weeks ☐ Every_____weeks
- Duration: ☐ 6 cycles ☐ 12 cycles ☐ Cessation trial (see Cessation Eligibility section)

SCIg DOSE REQUEST:

☐ Complete in conjunction with the SMH/JPOCSC Pre-Printed Orders and Patient Enrolment Notification for Subcutaneous Immune Globulin (SCIG) – Home Infusion Program (DRDO105213)

CESSATION ELIGIBILITY:

☐ Patient is eligible for trial of cessation
  - Last dose scheduled for: ☐ May *OR* ☐ _____ (specify month)

OR

☐ Cessation of Ig therapy is contraindicated, attach supporting consult notes with this PPO and indicate reason below:
  ☐ Underlying condition persists without significant improvement *AND* initial qualifying criteria met
  ☐ Neutrophils less than 0.5 x 10^9/L
  ☐ Immune-suppressant therapy: specify: _____
  ☐ Active bronchiectasis *AND*/*OR* ☐ Suppurative lung disease
  ☐ Continuation of Ig replacement specifically recommended by immunologist/designated expert

Date (dd/mm/yyyy)	Time	Prescriber Signature	Printed Name	College ID#