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

Form ID: DRDO107673A

New: November 16, 2022

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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:

<table>
<thead>
<tr>
<th>Date</th>
<th>Type/Site</th>
<th>Antibiotics</th>
<th>Cultures</th>
</tr>
</thead>
</table>

• 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 ☐ lgM g/L ☐ lgA 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 ☐ Q4 Weeks ☐ 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 10⁹/L
  ☐ Immune-suppressant therapy: specify: ___________
  ☐ Active bronchiectasis ☐ *AND*/*OR* ☐ Suppurative lung disease
  ☐ Continuation of Ig replacement specifically recommended by immunologist/designated expert

<table>
<thead>
<tr>
<th>Date (dd/mm/yyyy)</th>
<th>Time</th>
<th>Prescriber Signature</th>
<th>Printed Name</th>
<th>College ID#</th>
</tr>
</thead>
</table>