INSTRUCTIONS:
• If this is for a renewal request, complete Regional Pre-Printed Orders for Immune Globulin (Ig) Therapy for Secondary Immunodeficiency (SID) – Renewal Request (DRDO107673). (All Ig requests are screened in accordance with the BC Immune Globulin Utilization Management Program).

CRITERIA:
• In accordance with the BC Immune Globulin Utilization Management Program, orders that do not meet the mandate for SID will not be approved.
• Attach documentation / consultations to demonstrate evidence for ALL of the following and fax along with this pre-printed order (PPO):
  • Results of serum IgG measured on two separate occasions
  • Significant hypogammaglobulinemia with serum IgG less than 5 g/L (excluding paraprotein)
  • Exclusion of a pre-existing primary immunodeficiency (PIDD) (see PIDD diagnostic algorithm: https://www.pbco.ca)
  • At least one of the following:
    □ Referral to an immunologist or equivalent subspecialists with clinical expertise/ experience in management of SID
    □ At least one life threatening bacterial infection in the last 12 months* (e.g. ICU admission)
    □ At least 2 serious bacterial infections in the last 6 months requiring more than standard courses of antibiotics* (e.g. hospitalization, intravenous or prolonged antibiotic therapy)

*Infections must be unrelated to chemotherapy/radiation (e.g. neutropenia, mucosal toxicity) and must be confirmed to be or clinically consistent with encapsulated bacterial infection (e.g. Streptococcus pneumoniae, Haemophilus influenzae, and Neisseria meningitidis).

UNDERLYING CONDITION:
□ Chronic Lymphocytic Leukaemia  □ Multiple Myeloma  □ Non-Hodgkin Lymphoma
□ Transplant-related B cell Deficiency  □ Other (specify):_____________________

HISTORY:
• Which of the following infections has the patient experienced in the last 6 months, select all that apply:
□ Bronchiectasis  □ Recurrent bacterial infections
□ Sino-pulmonary infection  □ Other Bacterial (Specify):_____________________

LABORATORY:
• Baseline (within 6 months): IgG_____ g/L  IgM_____ g/L  IgA_____ g/L  Date:____________________
• Second IgG (suggest testing at 4 to 6 weeks post active infection): IgG_____ g/L  Date:____________________

PRODUCT:
□ Intravenous Immune Globulin (IVIg)
□ Subcutaneous Immune Globulin (SCIg)

IVIg DOSE REQUEST:
□ Loading Dose (give in conjunction with the first maintenance dose): If the IgG level is less than 4 g/L give 0.4 g/kg x1 dose
□ Maintenance 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

SCIg DOSE REQUEST:
□ Complete in conjunction with the SMHI/JPOCSC Pre-Printed Orders and Patient Enrolment Notification for Subcutaneous Immune Globulin (SCIG) – Home Infusion Program (DRDO105213)