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Santé et Services sociaux Québec

DT9489

NEUROLOGY Request for non-specific intravenous immunoglobulin (IVIG)

Patient last name, first name:	
Medical record number:	Sex ☐ M ☐ F
RAMQ:	Date of birth (yyyy/mm/ddj)
Healthcare Facility:	
Care unit:	

Section A: Prescriber and type of request — All sections are mandatory

Date of request (yyyy/mm/dd):	Expected date of treatment (yyyy/mm/dd):	Request number(s) (reserved for Blood Bank):
Prescribing physician (please print):		Location where the Ig will be administered:

Initial request (approved for a maximum of 6 months)

☐ Single dose ☐ 1 month ☐ 3 months ☐ 6 months

Renewal Request: A reassessment is required to confirm the effectiveness of treatment and ensure that the required minimum dose is prescribed (approved for a maximum of 12 months)

☐ 6 months ☐ 12 months

Section B: Patient information and clinical indication

Comments or other details:

Approved indications (Follow the doses and conditions of use provided on the back)

☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

☐ Guillain-Barré Syndrome (GBS) including Miller-Fisher Syndrome and other variants

☐ Multifocal Motor Neuropathy (MMN)

☐ Myasthenia Gravis (MG)

Other indications **(specify the diagnosis):**

Section C: Dosage information

The Dose Calculator tool must be used according to the instructions provided on the back: http://ivig.transfusionontario.org/dose/

Patient height: _____ cm Patient weight: _____ kg Dosage weight from the dose calculator: _____ kg ☐ N/A.

Single Dose	_____ g/kg = _____ g; divided over_____ days or Day 1_____ g, Day 2_____ g, Day 3_____ g
Maintenance Dose	_____ g/kg = _____ g; divided over_____ days; every _____ weeks; Duration: _____ months

Dose Calculator used ? ☐ Yes ☐ N/A ☐ No, specify the reason:

Section D: Signature of prescribing physician

Date (yyyy/mm/dd):	Time:	Signature of prescribing physician:	Licence No. (legible):

Send a copy of this form to the Blood Bank

Section E: Reserved for Blood Bank

☐ Dose verified by (signature of the technologist or nurse) : _____ Permit No.: _____

Dose adjusted: ☐ No ☐ Yes , adjusted to: _____

Authorized by (signature of physician): _____ Licence No.: _____

Patient last name, first name	Medical Record Number

General information	
An incomplete form will be returned to the prescriber and the request will only be processed upon receipt of a properly completed form.	
The **Dose Calculator** should be used to calculate doses for patients who are overweight or clinically obese, but it can be used safely for any user as it does not allow adjustment for a user less than 1.52 m (5 feet) or less than the ideal weight. **Calculation: Adjusted Dose =** Ideal Weight + [0.4 x (current – ideal weight)] If the current weight < ideal weight, the dose calculator will use the current weight to calculate the dose.	The Dose Calculator **must not** be used for: ➢ a patient whose height is less than 1.52 m (5 feet) ➢ a patient whose weight is less than 50kg ➢ a patient who is pregnant
Hemolytic reactions caused by anti-A or anti-B may be observed. The patient should be monitored for signs of hemolysis.	

Indications	Recommended dose and duration of treatment for non-specific intravenous immunoglobulin
Chronic Inflammatory Demyelinatin Polyneuropathy (CIDP)	▪ First-line treatment for severe or moderate disability ▪ In maintenance, monotherapy or in combination with immunosuppressants for users who respond to Ig ▪ Induction dose: 2g/kg over 2 to 5 days ▪ Maintenance dose: 0.4-1g/kg every 2 to 6 weeks (or relapse time)
Guillain-Barré Syndrome (GBS) including Miller-Fisher Syndrome and other variants	▪ Ideally within the first 2 weeks of symptom onset ▪ Severe or moderate disability ▪ Dose: 2g/kg over 2 to 5 days
Multifocal Motor Neuropathy (MMN)	▪ First-line treatment ▪ Induction dose: 2g/kg over 2 to 5 days ▪ Maintenance dose: 0.4-1 g/kg every 2-6 weeks (or relapse time)
Myasthenia Gravis (MG)	▪ In case of severe exacerbation or crisis ▪ In preparation for surgery if poorly controlled ▪ Total single dose: 2g/kg over 2 to 5 days ▪ Use in maintenance treatment must be justified

Recommended neurology doses and treatment times are taken from the *Institut national d'excellence en santé et en services sociaux (INESSS)* Guide for Optimal Use of Immunoglobulins in Neurology. Refer to the following link for details on the conditions of use for approved indications:
https://www.inesss.qc.ca/fileadmin/doc/INESSS/Rapports/Traitement/INESSS-immunoglobulins_neurology_EnglishSummary.pdf
https://www.inesss.qc.ca/fileadmin/doc/INESSS/Rapports/Traitement/GUO_Immunoglobulines_VF.pdf