IVIG Utilization in Manitoba

Frequently Asked Questions

1. **Who is responsible for completing the IVIG SCIG Physician Request Form?**

   The ordering physician must complete and sign the IVIG Physician Request Form.

2. **How do I know if the prescriber is on the approved prescriber list?**

   The list of approved prescribers will be maintained be Transfusion Medicine and copies will be circulated to all blood banks.

3. **Can a nurse complete the form and sign it on behalf of the physician?**

   No, it is the responsibility of the physician to complete and sign the form. In certain high utilization areas nurses will assist with the completion of the form but nurse's signatures will not be accepted.

4. **What is the difference between the ordering physician and the consulting physician?**

   The ordering physician may be the attending or the family physician. The ordering physician may be on the approved physician list. If the ordering physician is not on the approved list, a consulting physicians name must be present on the form. This implies that there has been adequate consultation with the physician on the approved list and this

physician agrees that it is the best option for this patient at this time. This applies to the initial and follows up forms.

5. **Where can I find the IVIG SCIG Physician Request Form?**

   Printed forms will be available in Blood Banks. Electronic forms will be available at bestbloodmanitoba.ca. Applicable clinical areas can order packages of 5 printed forms through SAP # 331889 for Initial Forms and #331891 for Follow up forms.

6. **Does the IVIG SCIG Physician Request Form replace the physician order?**

   No, a written physicians order is still required prior to the administration of IVIG/SCIG. This order is processed as it normally would be depending on the clinical area. The IVIG Physician Request Form provides BBM with the necessary information to ensure appropriate medical consultation has occurred for this treatment option.

7. **Do I send the IVIG SCIG Physician Request Form instead of the Request for Release Form?**

   No, the Request for Release Form is required in order for the blood bank to issue product. The Physician Request Form must accompany the Request for Release Form at the time of the initial treatment and every six months for subsequent treatments.

8. **What if the IVIG SCIG Physician Request Form is not completed and sent to Blood Bank?**

   The blood banks are unable to issue product without this mandatory documentation. The blood bank will contact the clinic or clinical care area if it is missing or incomplete.

9. **How will I know when the six month follow up IVIG SCIG Physician Request Form is required?**

   It is the responsibility of the prescriber to track patients on IVIG. BMS can assist physicians upon request.

10. Are there any exceptions to this process?

No. All adult and pediatric inpatients and outpatients that require IVIG or SCIG in Manitoba will be subject to this protocol.

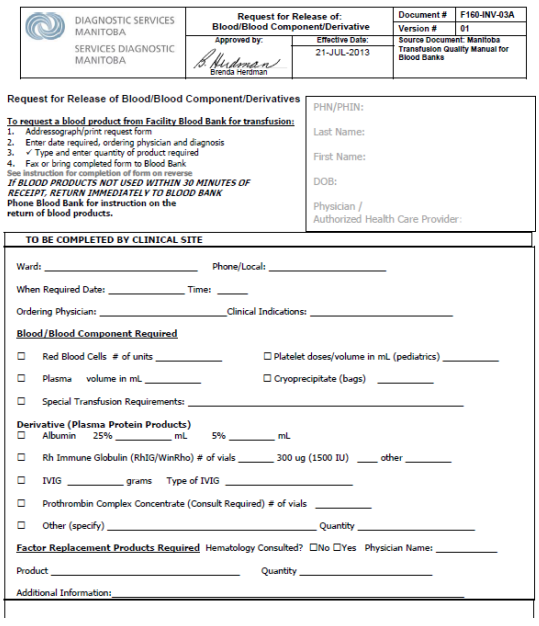
11. Who do I call for general information on this process?

For general information on this protocol visit bestbloodmanitoba.ca or contact BMS at 204-926-8006.

12. Who do I call for direction for specific patient requirements?

Contact the Transfusion Medicine physician on call for specific patient related inquiries.

Request for Release Form



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Request for Release of: Blood/Blood Component/Derivative	Document #	F160-INV-03A
	Version #	01
Approved by: Brenda Herdman	Effective Date: 21-JUL-2013	Source Document: Manitoba Transfusion Quality Manual for Blood Banks

Request for Release of Blood/Blood Component/Derivatives

To request a blood product from Facility Blood Bank for transfusion:
1. Addressograph/print request form
2. Enter date required, ordering physician and diagnosis
3. ✓ Type and enter quantity of product required
4. Fax or bring completed form to Blood Bank

See instruction for completion of form on reverse

IF BLOOD PRODUCTS NOT USED WITHIN 30 MINUTES OF RECEIPT, RETURN IMMEDIATELY TO BLOOD BANK
Phone Blood Bank for instruction on the return of blood products.

PHN/PHIN:
Last Name:
First Name:
DOB:
Physician / Authorized Health Care Provider:

TO BE COMPLETED BY CLINICAL SITE

Ward: _____ Phone/Local: _____

When Required Date: _____ Time: _____

Ordering Physician: _____ Clinical Indications: _____

Blood/Blood Component Required

☐ Red Blood Cells # of units _____ ☐ Platelet doses/volume in mL (pediatrics) _____

☐ Plasma volume in mL _____ ☐ Cryoprecipitate (bags) _____

☐ Special Transfusion Requirements: _____

Derivative (Plasma Protein Products)

☐ Albumin 25% _____ mL 5% _____ mL

☐ Rh Immune Globulin (RhIG/WinRho) # of vials _____ 300 ug (1500 IU) ____ other _____

☐ IVIG _____ grams Type of IVIG _____

☐ Prothrombin Complex Concentrate (Consult Required) # of vials _____

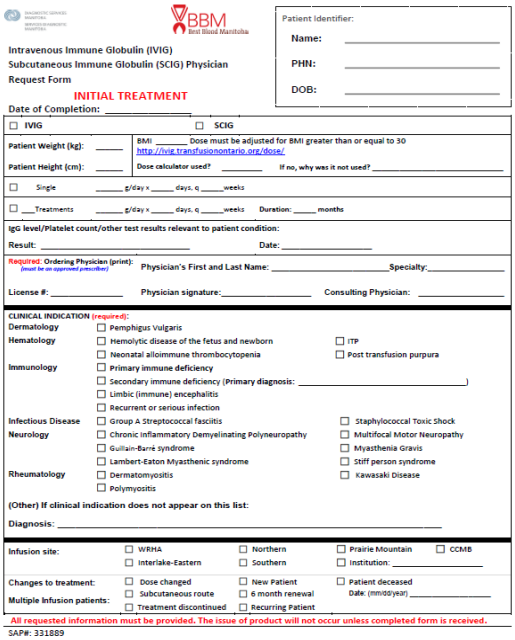
☐ Other (specify) _____ Quantity _____

Factor Replacement Products Required Hematology Consulted? ☐No ☐Yes Physician Name: _____

Product _____ Quantity _____

Additional Information: _____

IVIG Physician Request Form



BBM Best Blood Manitoba

Intravenous Immune Globulin (IVIG)
Subcutaneous Immune Globulin (SCIG) Physician Request Form

INITIAL TREATMENT

Patient Identifier:
Name: _____
PHN: _____
DOB: _____

Date of Completion: _____

☐ IVIG ☐ SCIG

Patient Weight (kg): _____ BMI: _____ Dose must be adjusted for BMI greater than or equal to 30 http://ivig.transfusionontario.org/dose/

Patient Height (cm): _____ Dose calculator used? _____ If no, why was it not used? _____

☐ Single _____ g/day x _____ days. q _____ weeks

☐ ___Treatments _____ g/day x _____ days. q _____ weeks Duration: _____ months

IgG level/Platelet count/other test results relevant to patient condition:

Result: _____ Date: _____

Required: Ordering Physician (print): (must be an approved prescriber) Physician's First and Last Name: _____ Specialty: _____

License #: _____ Physician signature: _____ Consulting Physician: _____

CLINICAL INDICATION (required):

Dermatology	☐ Pemphigus Vulgaris	
Hematology	☐ Hemolytic disease of the fetus and newborn	☐ ITP
	☐ Neonatal alloimmune thrombocytopenia	☐ Post transfusion purpura
Immunology	☐ Primary immune deficiency	
	☐ Secondary immune deficiency (Primary diagnosis: _____)	
	☐ Limbic (immune) encephalitis	
	☐ Recurrent or serious infection	
Infectious Disease	☐ Group A Streptococcal fasciitis	☐ Staphylococcal Toxic Shock
Neurology	☐ Chronic Inflammatory Demyelinating Polyneuropathy	☐ Multifocal Motor Neuropathy
	☐ Guillain-Barré syndrome	☐ Myasthenia Gravis
	☐ Lambert-Eaton Myasthenic syndrome	☐ Stiff person syndrome
Rheumatology	☐ Dermatomyositis	☐ Kawasaki Disease
	☐ Polymyositis	

(Other) If clinical indication does not appear on this list:

Diagnosis: _____

Infusion site:	☐ WRHA	☐ Northern	☐ Prairie Mountain	☐ CCMB
	☐ Interlake-Eastern	☐ Southern	☐ Institution: _____	
Changes to treatment:	☐ Dose changed	☐ New Patient	☐ Patient deceased	
Multiple Infusion patients:	☐ Subcutaneous route	☐ 6 month renewal	Date: (mm/dd/year) _____	
	☐ Treatment discontinued	☐ Recurring Patient		

All requested information must be provided. The issue of product will not occur unless completed form is received.

SAP#: 331889