Organising an IVIg (Intragram) infusion

Request

- Complete the 2 page IVIg Authorisation Request Form – Renal Indications (attached) or found at the Red Cross website https://www.blood.gov.au/system/files/IVIg-Authorisation-Request-for-Renal-Indications-Feb2017.pdf
- Fax to Red Cross ACT/NSW (fax number 9234 2050)

Urgent Infusion

- For urgent same day infusion contact Red Cross 1300 478 348
- Inform St George Hospital blood bank the request has been sent to the Red Cross

Elective Infusion

- Contact Red Cross on 1300 478 348 to confirm request form has been received
- Complete an Ambulatory Care Unit Referral Form and medication and fluid charts including pre-hydration, anticoagulation and medications to be given. The forms can be found in the 4W clinics and St George renal website
- Fax the referral form to Ambulatory Care Unit (fax number 31923)
- Call Ambulatory Care Unit (phone number 32333) to book date and time for the patient to attend for the infusion
- Inform patient of the appointment date, time and location of Ambulatory Care Unit

- The patient's caring medical team must complete a valid consent with the patient before the course of infusion begins

Reviewed April 2018

NATIONAL BLOOD AUTHORITY AUSTRALIA

INTRAVENOUS IMMUNOGLOBULIN (IVIg) NSW PATIENTS ONLY

Governance

Authorisation Request Form (Effective from February 2017)

RENAL INDICATIONS

About this form: This form is used for NSW patients only to request patient specific authorisation from the Australian Red Cross Blood Service (Blood Service) for initial access to immunoglobulin products, assessed against the Criteria for the clinical use of intravenous immunoglobulin in Australia Second Edition July 2012 (Criteria).
All fields must be completed and forms are to be faxed to relevant contact on page 2 of this form. Please note, incomplete forms will delay processing.

Tip: To move to the next field click TAB on your keyboard.

Requesting Medical Officer Name: **Position:**
Pager/Mobile: **Phone:** **Fax:** **Date:** (d/mm/yy)

PATIENT DETAILS (or affix hospital label)
Surname:
Given names:
DOB (d/mm/yy):
Gender: ☐ Female ☐ Male
UR:
Hospital:
Weight: kg Height: cm

PREVIOUS IMMUNOGLOBULIN TREATMENT:
☐ Yes ☐ No ☐ Unknown
Please provide details (including date, product and response, if known):

Treating facility (where clinically reviewed):
Administering facility (where Ig infused):

PRODUCT DELIVERY INSTRUCTIONS
Dispenser (hospital blood bank/pathology laboratory/pharmacy/private pathology)
Dispenser name:
Street:
Suburb:
State: Postcode:
Phone: Fax:
Email:
Additional delivery instructions:

PLEASE INDICATE PATIENT DIAGNOSIS. CONSULTANT'S LETTER MAY BE ATTACHED TO DEMONSTRATE THAT ALL QUALIFYING CRITERIA HAVE BEEN MET.

Diagnosis: **Transplant date:** (d/mm/yy)
Pre-transplant: ☐ ABO Incompatible ☐ Highly Sensitised (HLA)
Post-transplant: ☐ Antibody Mediated Rejection ☐ Steroid Resistant ☐ Cellular Rejection
☐ BK Virus ☐ CMV ☐ Other transplant risk (please specify):
☐ Conventional immunosuppression contraindicated Details (or attach letter):
Biopsy Results attached: ☐ Yes ☐ No Details (or attach letter):
Concurrent Therapy
☐ Plasma Exchange Number of Planned Exchanges: Dates:
☐ Immunosuppression Details (or attach letter):

DOSE REQUIRED: g **OR** Number of doses planned (e.g. 2x24g): DOSE/kg:
Frequency: (please specify) Date required: (d/mm/yy)

IMPORTANT: Your patient will be allocated either **Intragam P 6%** or an imported IVIg product provided your order meets policy requirements for the supply of IVIg for clinical indications funded under the Criteria. Some hospitals have local policies for imported IVIg product. Please check with your blood and blood products Dispenser (blood bank, pathology laboratory, pharmacy or private pathology).
Please indicate your preferred imported IVIg product:
☐ Privigen 10% ☐ Flebogamma 5% ☐ Flebogamma 10%

OFFICE USE ONLY (BLOOD SERVICE AUTHORISATION)
Delegate:
Qualifying Criteria: ☐ Met ☐ Not met
Referred to JDO/IVIg Group for Review: ☐ Yes ☐ No

Designation: (MO/TN/Other)
Request approved: ☐ Yes ☐ No
Product:
Dose: g
Frequency:

Review required by: (continuing supply will be conditional on this review)

Australian Red Cross BLOOD SERVICE

Reviewed April 2018

NATIONAL BLOOD AUTHORITY AUSTRALIA

INTRAVENOUS IMMUNOGLOBULIN (IVIg) NSW PATIENTS ONLY

Governance

Authorisation Request Form (Effective from February 2017)

RENAL INDICATIONS

PATIENT DETAILS

Surname: Given names:

DOB: Hospital:

REQUESTING MEDICAL OFFICER

Name: Position:

Pager/Mobile: Phone: Fax: Date:

RENAL PHYSICIAN/NEPHROLOGIST

Name: Phone:

Email: Mobile:

Postal address:

IMPORTANT: The addresses above will be used for any relevant future correspondence, including the patient treatment review outcome notification form for patients requiring continuing access to government funded immunoglobulin product. For some conditions, the Criteria require review by a specialist in a specific discipline - please refer to the Criteria.

Prescriber acknowledgement and confirmation (to be completed by the treating medical specialist or appropriate delegate following discussion with their patient)

I acknowledge the governance and management arrangements for the appropriate supply and use of immunoglobulin products, funded under the national blood arrangements, and the provision of information required to support authorisation. To the best of my knowledge, the information provided in this form and attachments is true and correct. I have provided and/or explained to my patient (or parent/carer/guardian) the Privacy Statement and Notice (Notice) and Patient Information Brochure and they have had the opportunity to ask questions. I believe that they are aware of and understand:

- the risks and benefits of treatment with immunoglobulin products and alternative treatments (where these exist),
- the national access conditions and governing requirements for the appropriate supply and use of immunoglobulin products under the national blood arrangements, including that immunoglobulin products may need to change from time to time
- (for patients requiring ongoing treatment only) the nature of ongoing monitoring and review and that access to product will cease if response to treatment does not demonstrate clinical benefit.

I confirm that my patient (or parent/carer/guardian) has provided express consent (explicit verbal or written consent) to:

- the collection and recording of personal information (including sensitive health information) in secure databases, held by the Australian Red Cross Blood Service (Blood Service) and the National Blood Authority (NBA),
- the use of this information by clinicians to submit a request for, and for the assessment of, initial or ongoing authorisation for access to publicly funded immunoglobulin products, against the criteria determined by clinical experts and approved by Australian governments for this purpose,
- the use of limited identifying details (for example, name, date of birth, sex and hospital identifiers) within search functions of the above mentioned databases to ensure that patients are correctly identified,
- the disclosure to and use of this information by clinicians in Australian treatment facilities that they attend for health care, in order to deliver health services according to the purposes set out in the Notice and
- the disclosure and use of this information in a manner which will not readily identify them, (such as through the removal of directly identifying personal information, or use of summary level grouped data) for the secondary purposes of: identifying priorities for research, prescriber education and training; performance evaluation and improvement of the supply, authorisation and use of immunoglobulin products; further developing the criteria upon which government policy is based; supply planning so the NBA can make sure enough Ig products are available to meet patients' needs; and enabling reporting on the program for supply, authorisation and use of publicly funded immunoglobulin products.

My patient understands that any additional use of information held by the Blood Service and NBA will only be undertaken in accordance with the requirements of the Privacy Act 1988 (Cth) and any relevant state/territory laws, and that the information may be made available for medical or public health research only with approval of a properly constituted human research ethics committee (HREC).

Signature: Date:

Name: Position:

The Australian Red Cross Blood Service is contracted by the National Blood Authority to perform the roles of Authoriser and Distributor of immunoglobulin products supplied and funded under the national blood arrangements.

PLEASE COMPLETE, PRINT, SIGN AND FAX TO THE RELEVANT FAX NUMBER PROVIDED BELOW.

STATE	FAX TO:	FOR URGENT ENQUIRIES
NORTHERN NSW, including: **Lismore Hospitals** **The Tweed Hospital** **Kyogle Memorial Hospital** **Murwillumbah District Hospital** **Byron Central Hospital**	07 3838 9421 (8:30am-4:30pm) or 07 3838 9400	07 3838 9223 (8:30am-4:30pm) or (After Hours 07 3838 9010)
NSW, All other sites	02 9234 2050	1300 478 348 (After Hours: 1300 478 348)

FOR **ALL STATES** OTHER THAN NSW, YOU MUST LOG INTO **BLOODSTAR** TO REQUEST IMMUNOGLOBULIN

For BloodSTAR Support contact the National Blood Authority - Blood Operations Centre on 13 000 BLOOD (13 000 25663) or support@blood.gov.au

Reviewed April 2018

Health
South Eastern Sydney
Local Health District

Facility: St George Hospital

REFERRAL – AMBULATORY CARE UNIT

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SES010413

☐ A/Prof Peter Smerdely ☐ Dr Marissa Antony ☐ Dr Louise Baird ☐ Dr Sarah Baldwin
☐ Dr Kannie Chuang ☐ Dr Nicholas Cordato ☐ Dr Jayita De ☐ Dr Chris Dedousis
☐ Dr Litsa Morfis ☐ Dr Grant Pickard ☐ Dr Tony Youssef ☐ Dr Yun Xu

Patient Family Name: _____ **Given Names:** _____

Date of Birth: ____/____/_____ **Gender:** ☐ Male ☐ Female

Address: _____

Phone Number: _____ **Mobile:** _____

Medicare Number: ☐☐☐☐☐☐☐☐☐☐ **Expiry Date:** ____/____/_____

Reason for referral: *(e.g. investigation of, type of treatment requesting - dressing, infusion, biopsy, transfusion)*

Treatment required: *(e.g. including drug name, dose frequency, volume of venesection)*

Diagnosis / Medical History:

GP Details

Name		**Phone Number**	
Address		**Fax Number**	

Interpreter Required ☐ Yes ☐ No **Language:**

Referring Doctor:	
Provider Number:	
Contact/Pager Number:	
Referring Doctors Signature:	
Date of Referral:	

ONCE REFERRAL FORM IS COMPLETE PLEASE FAX TO 9113 1923

OFFICE USE ONLY

Date referral received:		**Treatment Required in:**	☐ Bed ☐ Chair
Accepting Doctor:		**To be seen within:**	
Date Accepted:		**Interpreter Booked:**	☐ Yes ☐ No ☐ Not Available
Date of Appointment:			

NO WRITING

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

50536 12/16

REFERRAL – AMBULATORY CARE UNIT

SES010413

Reviewed April 2018