

# Organising an IVIg (Intragram) infusion

## **Request**

- Complete the 2-page IVIg Authorisation Request Form – Renal Indications (please see attached form)
- Fax the form to Red Cross ACT/NSW (fax number 9234 2050)

## **Urgent Infusion**

- For urgent same day infusion, contact Red Cross on 1300 478 348 (or after hours 1300 478 348).
- Inform St George Hospital blood bank the request has been sent to Red Cross.

## **Elective Infusion**

- Contact Red Cross on 1 300 478 348 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, transplant co-ordinator's office 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

## INTRAVENOUS IMMUNOGLOBULIN (IVIg) Authorisation Request Form (Effective from May 2016)

### RENAL INDICATIONS

**About this form:** This form is used 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.*

**State/Territory:**

**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/Territory:

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:**

**Available until 31 December 2015\***       Kiovig 10%       Octagam 5%       Octagam 10%

\* These products are available for existing patients until 30 June 2016.

**Available from 1 November 2015**       Privigen 10%       Flebogamma 5%       Flebogamma 10%

**OFFICE USE ONLY (BLOOD SERVICE AUTHORISATION)**

Delegate:

Designation: (MO/TN/Other)

Qualifying Criteria:  Met       Not met

Request approved:                       Yes       No

Referred to JDO/IVIg Group for Review:  Yes       No

Product:

Dose:    g

Frequency:

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

# INTRAVENOUS IMMUNOGLOBULIN (IVIg)

## Authorisation Request Form (Effective from May 2016)

### 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 lg 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
<b>ACT/NSW</b>	02 9234 2050	1300 478 348 (After Hours: 1300 478 348)
<b>QLD</b>	07 3838 9421 (8:30am-4:30pm) or 07 3838 9400	07 3838 9223 (After Hours: 07 3838 9010)
<b>SA</b> (direct to relevant hospital contact)	<b>RAH:</b> 08 8222 3076 <b>FMC:</b> 08 8204 3191 <b>CYWHS:</b> 08 8161 6043 <b>TQEH:</b> 08 8222 6685 <b>LMH:</b> 08 8182 9880 <b>Other hospitals:</b> 08 8223 5833 (After Hours: 08 8232 5741)	08 8222 5430 (After Hours: 08 8222 5430) 08 8204 5291 (After Hours: 08 8204 5291) 08 8161 6320 (After Hours: 08 8161 6320) 08 8222 6652 (After Hours: 08 8222 6652) 08 8182 9286 (After Hours: 08 8182 9286) 08 8112 1341 (After Hours: 08 8223 6090)
<b>TAS</b>	03 6230 6298	03 6230 6209 (After Hours: 0419 517 249)
<b>VIC</b>	03 9694 0245	03 9694 0200 (After Hours: 03 9694 0200)
<b>WA</b>	08 9221 1215	08 9421 2377 (After Hours: 08 9325 3030)

This fax message and any attached files may contain information that is confidential including health information intended only for use by the individual or entity to whom they are addressed. If you are not the intended recipient or the person responsible for delivering the message to the intended recipient, be advised that you have received this message in error. To protect the privacy of individuals in this form you should notify the sender immediately and shred the fax.



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

S0638 280313



Health  
South Eastern Sydney  
Local Health District

FAMILY NAME: \_\_\_\_\_  
GIVEN NAME: \_\_\_\_\_  MALE  FEMALE

Facility: \_\_\_\_\_

D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ M.O. \_\_\_\_\_

## REFERRAL - AMBULATORY CARE UNIT

ADDRESS: \_\_\_\_\_  
LOCATION / WARD: \_\_\_\_\_  
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

- Prof Peter Smerdely     Dr Louise Baird     Dr Sarah Baldwin     Dr Kannie Chuang     Dr Chris Dedousis
- Dr Litsa Morfis     Dr Grant Pickard     Dr Tony Youssef     Dr Yun Xu

Patient Family Name: \_\_\_\_\_ Given Name: \_\_\_\_\_

DOB: \_\_\_\_\_ MALE / FEMALE: (please circle)

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_ Mobile No: \_\_\_\_\_

Medicare No:  Medicare Expiry Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
*Note: - include patient's reference number as the eleventh number of the Medicare card.*

Interpreter Required: Yes / No Dialect: \_\_\_\_\_

Reason for referral:

Diagnosis/Medical History:

If medication required please complete the Community Medication and Authorisation Record

Please tick if patient arriving by ambulance.

Referral Dr: \_\_\_\_\_ Contact No / Page No: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Referring Dr	
Provider No.	
Telephone	
Address	

Please complete this section in full or with practice stamp  
Fax completed form: 9113 1923

Practice Stamp

NO WRITING



REFERRAL - AMBULATORY CARE UNIT    SES010.413