UNIVERSITI SAINS MALAYSIA
APEX™

Jabatan Farmasi
Hospital Universiti Sains Malaysia

HUMAN IMMUNOGLOBULIN PRESCRIPTION AUTHORISATION (HIPA)

*Drug Restricted for Medical, Paediatric and Anaesthesiology specialization use only.

PATIENT INFORMATION

Name	:		
RN	:	Age	:
Ward	:	Bed	:
Gender	: ☐ Male ☐ Female	Weight	:

INDICATION (S) FOR HUMAN IMMUNOGLOBULIN*(Please tick (✓) accordingly.)

Refractory Idiopathic Thrombocytopenia Purpura/ Immune Thrombocytopenia (ITP)		Demyelinating Disease - Paediatric and Neurology	
X-Linked Agammaglobulinemia		Immune Mediated Anaemia (Eg: ABO Incompatibility) – Paediatric	
Systemic Lupus Erythematosus (SLE)		Overwhelming Sepsis - Paediatric	
Kawasaki Disease		Primary Immunodeficiency – Paediatric	
Necrotising Fasciitis		Immune Mediated or Paraneoplastic Encephalitis – Neurology	
Toxic Epidermal Necrolysis (TEN)		Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) – Neurology	
Guillain Barre-Syndrome (GBS)		Multifocal Motor Neuropathy (MMN) – Neurology	
Myasthenia Gravis		Immune Mediated Vasculitis Polyneuropathy – Neurology	
Toxic Shock Syndrome Streptococcus (TSSS)		Inflammatory Myopathy – Neurology	
Varicella post-exposure in an immunocompromised patient		Super Refractory Status Epilepticus - Neurology	
COVID-19 patient - Kawasaki Disease-like features		COVID-19 patient - Multisystem Inflammatory Syndrome in Children (MIS-C)	
COVID-19 patient - Patient with significant Left Ventricular (LV) Dysfunction			

DOSE REGIMEN

DOSE	(….. GRAM/KG)	FREQUENCY	DURATION	TOTAL VIAL (TO BE FILLED BY PHARMACY)

PRESCRIBER (SPECIALIST/MEDICAL OFFICER)

SIGNATURE	OFFICIAL STAMP	DATE	CONSULTANT PHYSICIAN
			Name:
			Specialization*: ☐ Medical ☐ Paediatric ☐ Anaesthesiology

*Please tick (✓) accordingly.

NOTE:

1) This form needs to be submitted with medication chart for drug supply.
2) Incomplete form will be rejected and drug will not be supplied.
3) For indication other than listed above or other specialization, to follow the Standard Operating Procedure (SOP) of non-standard drug with buffer.

TO BE FILLED BY PHARMACY

TOTAL VIALS REQUIRED: _______ VIALS

NUM.	DATE	QUANTITY SUPPLIED	SUPPLIED BY (*PLEASE WRITE NAME)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			