Phone: 866.506.2626 • Fax: 800.696.0607

Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Prescriber
☐ Nursing needed; ☐ Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

SUBCUTANEOUS IMMUNE GLOBULIN (SCIg) INFUSION REFERRAL FORM (2 Pages)

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ☐ M ☐ F ☐ Other:	Weight:	☐ lbs. ☐ kg.	Height:
SSN:	Phone:	Allergies:				
Address:		City:	State:	Zip:		
Emergency Contact:		Phone:	☐ **Additional Information Attached**			

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

PRESCRIBER INFORMATION

Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:	Practice Name:		
Address:	City:	State:	Zip:
Phone: Fax:	Key Office Contact:		Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Diagnosis: ☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) ☐ Primary Immunodeficiency (PI) ☐ Other: _____

Treatment Setting & Patient Training: Initial Treatment Setting: ☐ Patient's Home ☐ Physician Office ☐ Outpatient Clinic ☐ Inpatient
Final Treatment Setting: ☐ Patient's Home ☐ Physician Office ☐ Outpatient Clinic ☐ Inpatient

- **First SQIg Infusion?:** ☐ Yes ☐ No If yes, was patient on IVIG infusion?
  ☐ Yes, Last infusion Date: _____/_____/_____ Last infusion dose and frequency: _____
  ☐ No, IgA level is more than 5 mg/dl: ☐ Yes ☐ No ☐ Not Available ☐ Ig Quantitation: IgA, IgG, IgM (prior to 1st IVIG infusion)
- **Labs:** To be monitored by MD prior to infusion and again at appropriate intervals thereafter: ☐ CBC with Differential ☐ Basic Metabolic Panel (BMP) ☐ Other: _____
- **SCIg Home Training by RN (Certified for SCIg Infusion):** First SQIg Infusions to be administered by RN ☐ Yes ☐ No

IMMUNE GLOBULIN SUBCUTANEOUS "HUMAN" ORDER: (will dispense available increment)

☐ **Gammagard 10%** ☐ **Gamunex-C 10%** ☐ **Hizentra 20% Vial** ☐ **Hizentra 20% Prefilled Syringe** ☐ **Xembify 20%**
DOSE CALCULATION: **Initial weekly dose (in gm)** = 1.37 x [previous IVIG dose (gm) / number of weeks between IVIG doses]

☐ **Cutaquig 16.5%**
DOSE CALCULATION: **Initial weekly dose (in gm)** = 1.4 x [previous IVIG dose (gm) / number of weeks between IVIG doses]

☐ **Cuvitru 20%**
DOSE CALCULATION: **Initial weekly dose (in gm)** = 1.30 x [previous IVIG dose (gm) / number of weeks between IVIG dose]

☐ **HyQvia PI** Optional Infusion Trays: ☐ Hyhub *(OR)* ☐ HyHub Duo *(for patients 17+ as prescribed)* ☐ No Ramping Required ☐ Ramping Required
*** **Specify frequency:** ☐ every 2 weeks ☐ every 3 weeks ☐ every 4 weeks *(Ramping up dose may take 3 to 7 weeks depending on frequency)*

DOSE CALCULATION: ***Based on every 4 weeks frequency for PI***
Week 1 dose (in gm) = 0.25 x full dose; **Week 2 dose (in gm)** = 0.5 x full dose; **Week 3** = No Infusion;
Week 4 dose (in gm) = 0.75 x full dose; **Week 5 & 6** = No Infusion; **Week 7 dose (in gm)** = 100% of the full dose of previous monthly IVIG dose

DOSE CALCULATION: ***Based on every 3 weeks frequency for PI***
Week 1 dose = 33% of the full dose; **Week 2 dose** = 66% of the full dose; **Week 3 dose** = No Infusion; **Week 4 Dose** = 100% of the full dose; *Continue every 3 weeks at 100% of the full dose*

☐ **HyQvia CIDP** Optional Infusion Trays: ☐ Hyhub *(OR)* ☐ HyHub Duo *(for patients 17+ as prescribed)* ☐ No Ramping Required ☐ Ramping Required
*** **Specify frequency:** ☐ every 2 weeks ☐ every 3 weeks ☐ every 4 weeks *(Ramping up dose may take 4 to 9 weeks depending on frequency)*

DOSE CALCULATION: ***Based on every 4 weeks frequency for CIDP***
Week 1 dose = No Infusion; **Week 2 dose (in gm)** = 0.25 x [previous IV monthly dose (gm)]; **Week 3 dose (in gm)** = 0.25 x [previous IV monthly dose (gm)];
Week 4 dose (in gm) = 0.50 x [previous IV monthly dose (gm)]; **Week 5** = No Infusion; **Week 6 dose (in gm)** = 0.75 x [previous IV monthly dose (gm)];
Week 7 & 8 = No Infusion; **Week 9 dose (in gm)** = 100% of the full dose of previous monthly IVIG dose; *Continue every 4 weeks at 100% of the full dose*

DOSE CALCULATION: ***Based on every 3 weeks frequency for CIDP***
Week 1 dose = No Infusion; **Week 2 dose** = 33% of the full dose; **Week 3 dose** = 33% of the full dose; **Week 4 dose** = 66% of the full dose;
Week 5 dose = No Infusion; **Week 6 dose** = 100% of the full dose; *Continue every 3 weeks at 100% of the full dose*

DOSE CALCULATION: ***Based on every 2 weeks frequency for CIDP***
Week 1 dose = No Infusion; **Week 2 dose** = 50% of the full dose; **Week 3 dose** = 50% of the full dose; **Week 4 dose** = 100% of the full dose;
Continue every 2 weeks at 100% of the full dose

DOSAGE: (will use available increment / combination of vial sizes for each dose; each dose will be rounded to next vial size)

Dosage: _____ gm (_____ mL) to be infused subcutaneously over _____ hours as tolerated
☐ Weekly *OR* Every _____ weeks Dispensed every 4 weeks with supplies Refills: _____

PRE-MEDICATIONS: To be Administered 30 Minutes Prior to SC Infusion (Optional)

☐ Diphenhydramine 25 - 50 mg PO QTY: #2 (25 mg) ☐ Acetaminophen 650 mg PO QTY: #2 (325 mg) ☐ Other: _____ QTY: QS

PROCEDURE FOR ACUTE HYPERSENSITIVITY AND/OR ANAPHYLAXIS

STOP Infusion and call 911 & MD

- Epinephrine (adult) 0.3 mg IM x 1, may repeat or (pedi) based on pts. weight
- Other: _____ QTY: _____

Prescriber's Signature: _____ ☐ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

Patient Name: DOB:

Instructions for SCIg Administration

- SCIg Home Training by RN (Certified for SQIg Infusion): First SQIg Infusions to be administered by RN
- Obtain baseline vital signs (T, P, R, BP)
- Vital signs every 15 minutes for the 1st hour, then every 30 minutes for the remainder of infusion
- Assure that patient is not volume depleted prior to initiation of SQIg Infusion

NUMBER OF SIMULTANEOUS INJECTION SITES

Number of simultaneous infusion sites: _____

☐ **SQ needle set:** ☐ **Single lumen (1)** ☐ **Bifurcated (2)** ☐ **Trifurcated (3)** ☐ **Quadfurcated (4)** ☐ **Pentafurcated (5)** ☐ **Hexafurcated (6)**
(based on max number of injections per site may need to use combination of SQ needle set)

☐ **Cutaquig 16.5%**
- First 6 Infusions = 15 mL - 20 mL per hour, per site; Subsequent Infusion = 25 mL per hour, per site up to a total of 6 sites

☐ **Cuvitru 20%**
- First 2 Infusions = 10 mL - 20 mL per hour, per site; Subsequent Infusion ≤ 60 mL per hour, per site up to a total of 4 sites at least 4 inches apart

☐ **Gammagard 10%** CONVERSION: Gammagard 10% dose _____ gm **x 10** = _____ mL
- Infusion volume per hour per site: If weight **OVER** 40 kg = 20 mL/hr/site initially. May increase to 30 mL/hr/site as tolerated
  If weight **UNDER** 40 kg = 15 mL/hr/site initially. May increase to 20 mL/hr/site as tolerated
- Maximum number of simultaneous sites: 8 infusion sites, at least 2 inches apart

☐ **Gamunex-C 10%** CONVERSION: Gamunex-C 10% dose _____ gm **x 10** = _____ mL
- Infusion volume per hour per site: **Ped:** < 25 kg weight = 10 mL/hr/site; **Ped:** > 25 kg weight = 15 mL/hr/site to 20 mL/hr/site with max of 6 sites
  Adult: 20 mL/hr/site with maximum of 8 sites, at least 2 inches apart simultaneously

☐ **Hizentra 20%** CONVERSION: Hizentra 20% dose _____ gm **x 5** = _____ mL
- Infusion volume per hour per site: **For PI:** Initially up to 15 mL/hr/site; Increase up to 25 mL/hr/site as tolerated
  For CIDP: Initially up to 20 mL/hr/site; Increase up to 50 mL/hr/site as tolerated
- Maximum number of simultaneous sites: 8 infusion sites, at least 2 inches apart

☐ **HyQvia PI** CONVERSION: HyQvia-IG dose _____ gm **x 10** = _____ mL; HyQvia-HY dose _____ gm **/ 2** = _____ mL
- Infusion volume per hour per site (maximum of 2 sites allowed but must be on opposite sides of the body in abdomen or thigh):
- First 2 infusions into 1 site if weight is < 40 kg, maximum rate is 80 mL/hr/site; Subsequent infusions maximum rate is 160 mL/hr/site
- First 2 infusions into 1 site if weight is > 40 kg, maximum rate is 240 mL/hr/site; Subsequent infusions maximum rate is 300 mL/hr/site
- If 2nd site is used then administer ½ the total volume in each site
- For PI, maximum number of simultaneous sites is 2 infusion sites, at least 2 inches apart

☐ **HyQvia CIDP** CONVERSION: HyQvia-IG dose _____ gm **x 10** = _____ mL; HyQvia-HY dose _____ gm **/ 2** = _____ mL
- Infusion volume per hour per site (maximum of 3 sites allowed in abdomen or thigh):
- First 2 infusions into 1 site if weight is < 40 kg, maximum rate is 80 mL/hr/site; Subsequent infusions maximum rate is 160 mL/hr/site
- First 2 infusions into 1 site if weight is > 40 kg, maximum rate is 240 mL/hr/site; Subsequent infusions maximum rate is 300 mL/hr/site
- Maximum number of simultaneous sites is 3 infusion sites, at least 4 inches apart; **If using 3 sites, the maximum rate is 400 mL/site**

☐ **Gammagard 10%** INFUSION RATE: _____ mL/hr per site as tolerated (please indicate if different than suggested infusion rate)
- Initial Infusion Rate: If weight is > than 40 kg = 20 mL/hr per site ***OR*** If weight is < than 40 kg = 15 mL/hr per site
- Maximum Infusion Rate: If weight is > than 40 kg = 30 mL/hr per site ***OR*** Maximum Infusion Rate 240 mL/hr for all sites combined
  If weight is < than 40 kg = 20 mL/hr per site ***OR*** Maximum Infusion Rate 160 mL/hr for all sites combined

☐ **Gamunex-C 10%** INFUSION RATE: _____ mL/hr per site as tolerated (please indicate if different than suggested infusion rate)
- Suggested Infusion Rate = 20 mL/hr per site

☐ **Hizentra 20%** INFUSION RATE: _____ mL/hr per site as tolerated (please indicate if different than suggested infusion rate)
- FIRST Infusion = 15 mL/hr per site; SECOND and Subsequent Infusions = if no reaction may be increased to a maximum of 25 mL/hr per site as tolerated
- Maximum Infusion Rate: Should NOT exceed a total of 50 mL/hr for all sites combined

☐ **Xembify 20%** INFUSION RATE: _____ mL/hr per site
- Maximum Infusion Rate ≤ 25 mL/hr per site up to a maximum of 6 sites, at least 2 inches apart

POSSIBLE SYMPTOMS (RN to monitor and train patient) discontinue infusion and notify MD if:

- Malaise, chest tightness, a feeling of faintness, dyspnea, fever/chills, chest/back or hip pain, nausea/vomiting, mild erythema, hypotension/hypertension, headache, fatigue, leg cramps, lightheadedness, fever, urticaria, flushing AMS (aseptic meningitis syndrome)
- STOP the infusion and notify MD ASAP
- Patient should be instructed to report symptoms of decreased urine output, sudden weight gain, fluid retention and/or shortness of breath

PATIENT EDUCATION

- RN to educate/train patient on SC-Infusion
- RN to educate patient on the possible adverse reactions including: injection site reaction (i.e.: swelling, redness, heat, pain and/or itching at the injection site), headache, vomiting, pain and/or fatigue

SUPPLIES (needed supplies, including needles and syringes, will be sent based on ordered dose and frequency)

- Freedom 60 pump, 50 mL syringe-BD, rate controlled tubing set, SC needle set, transparent dressing/sterile gauze, alcohol pads, band aids, gloves, sterile towel drape, sharps container

Prescriber's Signature: _____ ☐ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.