

## Subcutaneous Immunoglobulin (SCIG) | Order Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### 1. For new patients, please submit with form:

- Copy of insurance card     Demographics     History & physical     Labs     Testing results supporting diagnosis  
 Baseline assessment (include medications tried and failed if any)

### 2. Patient Information

Male  Female Height: \_\_\_\_\_ in/cm Weight: \_\_\_\_\_ lbs/kg Allergies: \_\_\_\_\_

#### History of immunoglobulin (IG) therapy:

- New to IG therapy     Continuing on SCIG     Switching from IVIG to SCIG\*. Current IVIG product/dose/frequency: \_\_\_\_\_  
 \*Note: SCIG will begin 1 week after final dose of IVIG if possible, unless otherwise specified by prescriber  
 Date of final IVIG infusion before switching to SCIG: \_\_\_\_\_ Date desired for first SCIG infusion: \_\_\_\_\_

### 3. Diagnosis and Clinical Information

ICD-10 (required): \_\_\_\_\_

- Primary diagnosis:  Congenital hypogammaglobulinemia     CVID     SCID     CIDP     Multifocal motor neuropathy     Multiple sclerosis  
 Guillain-barré syndrome     Myasthenia gravis     Polymyositis     Dermatomyositis     Other \_\_\_\_\_

### 4. Prescription Information

<b>SCIG Product</b>	<input checked="" type="checkbox"/> SCIG: pharmacist to select product based on patient specific factors and notify provider of selection <input type="checkbox"/> Specific SCIG product required (list product): _____
<b>Loading Dose</b>	IVIG – Product: <input type="checkbox"/> Unbranded (pharmacist to select product) or <input type="checkbox"/> Brand required: _____ Administer _____ grams OR _____ grams/kg* IV divided over _____ day(s) one time Other: _____
<b>Maintenance SCIG Dose</b>	Dose: _____ grams OR _____ grams/kg* (rounded to nearest whole vial size) <input type="checkbox"/> *If weight is >130% ideal body weight (IBW), use adjusted body weight (IBW+0.4[ABW-IBW]) to calculate dose Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Other: _____
<b>SCIG Administration</b>	<input checked="" type="checkbox"/> Infuse subcutaneously via infusion pump, using 1 or more sites, adjusted as tolerated per manufacturer guidelines OR infuse in _____ site(s) using _____ rate flow tubing over _____ minutes <input type="checkbox"/> Other: _____
<b>Quantity / Refills</b>	Dispense 1 month supply / Refill x 12 months <input type="checkbox"/> Other: _____ Dispense all medical supplies necessary for infusion

### 5. Additional Orders

- For IV loading dose (if ordered): RN to start peripheral IV or existing CVC. RN to administer catheter flushing per PromptCare Policy and Procedure  
 RN may instruct patient to hydrate pre/post infusion and educate on taking **OTC diphenhydramine and/or acetaminophen** per manufacturer dosing recommendations as needed to prevent/treat post-infusion headache.  
 Skilled nursing services to be provided for infusion, assessment and teaching of SCIG as needed  
 Other: \_\_\_\_\_

### 6. Adverse Reaction Orders

- For SCIG: Prescriber to send separate prescription to retail pharmacy of patient's choice for epinephrine pen, for use in anaphylactic reaction  
 For IVIG **only**: Standard anaphylaxis kit to be dispensed and dosed per protocol: Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL vial), and NS IV

### 7. Prescriber Information

Prescriber Name: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 License No.: \_\_\_\_\_ DEA NO.: \_\_\_\_\_ NPI: \_\_\_\_\_

Physician Signature (Substitution Permitted)

Date

Physician Signature (Dispense as Written)

Date

*By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. PromptCare has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.*

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