

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 (SQIg) INFUSION REFERRAL FORM (2 Pages)

PATIENT INFORMATION					
Patient Name:		DOB:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg.	
SSN:		Phone:		Allergies:	
Address:			City:		State:
Emergency Contact:			Phone:		<input type="checkbox"/> Please attach demographic information
INSURANCE INFORMATION					
<input type="checkbox"/> Please attach front and back of patient's insurance card (medical and prescription)					
PRESCRIBER INFORMATION					
Prescriber:		NPI:		DEA:	
Supervising Physician:			Practice Name:		
Address:			City:		State:
Phone:		Fax:		Key Office Contact:	
				Phone:	
DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT					
Diagnosis: <input type="checkbox"/> Primary Immunodeficiency (PI) <input type="checkbox"/> Other: _____ Treatment Setting & Patient Training: Initial Treatment Setting: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician Office <input type="checkbox"/> Outpatient Clinic <input type="checkbox"/> Inpatient Final Treatment Setting: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician Office <input type="checkbox"/> Outpatient Clinic <input type="checkbox"/> Inpatient <ul style="list-style-type: none"> ▪ First SQIg infusion: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was patient on IVIG infusion? <input type="checkbox"/> Yes, Last infusion Date ____/____/____ Last infusion dose and frequency _____ <input type="checkbox"/> No, IgA level is more than 5 mg/dl: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Available <input type="checkbox"/> 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: <input type="checkbox"/> CBC with Differential <input type="checkbox"/> Basic Metabolic Panel (BMP) <input type="checkbox"/> Other _____ ▪ SQIg Home Training by RN (Certified for SQIg infusion): First SQIg infusions to be administered by RN <input type="checkbox"/> Yes <input type="checkbox"/> No 					
IMMUNE GLOBULIN SUBCUTANEOUS "HUMAN" ORDER: (will dispense available increment)					
<input type="checkbox"/> Gammagard 10% Order's increments: <input type="checkbox"/> 10 ml (1 gr) <input type="checkbox"/> 25 ml (2.5 gr) <input type="checkbox"/> 50 ml (5 gr) <input type="checkbox"/> 100 ml (10 gr) <input type="checkbox"/> 200 ml (20 gr) <input type="checkbox"/> 300 ml (30gr) Dose Calculation: Initial weekly dose (in gr) = 1.37 x [previous IVIG dose (gr) / number of weeks between IVIG doses] <input type="checkbox"/> Gamunex-C 10% Order's increments: <input type="checkbox"/> 10 ml (1 gr) <input type="checkbox"/> 25 ml (2.5 gr) <input type="checkbox"/> 50 ml (5 gr) <input type="checkbox"/> 100 ml (10 gr) <input type="checkbox"/> 200 ml (20 gr) <input type="checkbox"/> 400 ml (40 gm) latex free Dose Calculation: Initial weekly dose (in gr) = 1.37 x [previous IVIG dose (gr) / number of weeks between IVIG doses] <input type="checkbox"/> Hizentra 20% Order's increments: <input type="checkbox"/> 5 ml (1 gr) <input type="checkbox"/> 10 ml (2 gr) <input type="checkbox"/> 20 ml (4 gr) <input type="checkbox"/> 50 ml (10 gr) <input type="checkbox"/> Hizentra 20% Prefilled Syringe: <input type="checkbox"/> 5ml (1 gr) <input type="checkbox"/> 10ml (2 gr) <input type="checkbox"/> 20ml (4 gr) Dose Calculation: Initial weekly dose (in gr) = 1.37 x [previous IVIG dose (gr) / number of weeks between IVIG doses] <input type="checkbox"/> HyQvia Order's increments: IG- <input type="checkbox"/> 25 ml (2.5 gr) <input type="checkbox"/> 50 ml (5 gr) <input type="checkbox"/> 100 ml (10 gr) <input type="checkbox"/> 200 ml (20 gr) <input type="checkbox"/> 300 ml (30 gr) Order's increments: HY- <input type="checkbox"/> 1.25 ml (2.5 gr) <input type="checkbox"/> 2.5 ml (5 gr) <input type="checkbox"/> 5 ml (10 gr) <input type="checkbox"/> 10 ml (20 gr) <input type="checkbox"/> 15 ml (30 gr) Dose Calculation: Week 1 dose (in gr) = 0.25 x [previous IV / SQ monthly dose (gr)], Week 2 dose (in gr) = 0.5 x [previous IV / SQ monthly dose (gr)], Week 3: No Infusion, Week 4 dose (in gr) = 0.75 x [previous IV / SQ monthly dose (gr)], Week 5 & 6: No Infusion, Week 7 dose if needed (in g) = full previous dose IV / SQ monthly dose, then 3-4 weeks thereafter					
DOSAGE: (will use available increment / combination of vial sizes for each dose. Each dose will be rounded to next vial size).					
Dosage: _____ gr (_____ ml) to be infused subcutaneously over _____ hours as tolerated <input type="checkbox"/> Weekly <input type="checkbox"/> times per week <input type="checkbox"/> Every _____ Qty: 4 weeks supply Refill: _____					
Pharmacist to calculate: Previous Monthly SQ/IV Dose HyQvia Ramp Up: <ul style="list-style-type: none"> ▪ Week 1 _____ gr to be infused over _____ hours into _____ sites ▪ Week 2 _____ gr to be infused over _____ hours into _____ sites ▪ Week 4 _____ gr to be infused over _____ hours into _____ sites ▪ Week 7 _____ gr to be infused over _____ hours into _____ sites HyQvia Maintenance Dose: After initial ramp up: 300-600mg/kg q3-4 weeks gr to be infused over _____ hours into _____ sites Qty: 4 weeks supply Refills: _____					
PRE-MEDICATIONS: To be Administered 30 Minutes Prior to SQ Infusion(Optional)					
<input type="checkbox"/> Diphenhydramine 25-50mg PO QTY: #2 (25mg) <input type="checkbox"/> Acetaminophen 650mg PO QTY: #2 (325mg) <input type="checkbox"/> Other _____ QTY: QS					
Procedure for Acute Hypersensitivity and/or Anaphylaxis					
STOP Infusion and call 911 & MD <ul style="list-style-type: none"> ▪ Benadryl 25 - 50 mg IVP every 4 hours prn (Rate not to exceed 25 mg/min) <input type="checkbox"/> to be administered by a nurse QTY: 3 (50 mg) ▪ EpiPen (adult) 0.3 mg IM x 1, may repeat QTY: 3 ▪ Other: _____ QTY: _____ 					

Please see second page

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 prescription electronically or on official state prescription blank. Prescriber authorizes AcariaHealth to forward this prescription to another pharmacy, if needed. IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.

Phone: 866.506.2626 • Fax: 800.696.0607

Instructions for SQIg Administration

- SQIg 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 no max number of injections per site may need to use combination of SQ needle set)

Gammagard 10%: Conversions: Gammagard 10% dose ___gr x 10 = _____ml

- Infusion volume per site: If weight more than 40 kg: 30 ml/site
- If weight less than 40 kg: 20ml/site
- Maximum number of simultaneous sites: 8 infusion sites, at least 2 inches apart

Gamunex-C 10%: Conversions: Gamunex-C dose ___gr x 10 = ___ml

- Infusion volume per site (recommended mean volume): 34 ml/site
- Maximum number of simultaneous sites: 8 infusion sites, at least 2 inches apart

Hizentra 20%: Conversions: Hizentra dose _____gr x 5 = _____ml

- Infusion volume per infusion site:
- First infusion: up to 15 ml/site
- After the 4th infusion: may increase to 20 ml/site (Maximum Volume: 25 ml/ site as tolerated)

HyQvia: Conversions: HyQvia-IG dose _____gr x 10 = _____ml HyQvia-HY dose _____gr / 2 = ___ml

- Infusion volume per infusion site (Maximum of 2 sites allowed but have to be on opposite sides of the ody in abdomen or thigh): 1st site if ≥ 40 kg = 600 ml/site and 1st site if < 40 kg = 300 ml/site 2nd site is used then administer ½ the total volume in each site = 300 ml/site if ≥ 40 kg and 150 ml/site if < 40 kg. Maximum number of simultaneous sites: 4 infusion sites, at least 2 inches apart

Gammagard 10% Infusion Rate: _____ml/hr per site as tolerated (please indicate if different than suggested infusion rate)

- Initial Infusion Rate: If weight is more than 40 kg: 20 ml/hr/site OR If weight is less than 40 kg: 15 ml/hr/site
- Maximum Infusion Rate: If weight more than 40 kg: 30 ml/hr/site (OR: maximum infusion rate 240 ml/hr for all sites combined) If weight less than 40 kg: 20 ml/hr/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)

- 1st infusion: 15ml/hr/site
- 2nd and subsequent infusions: if no reaction may be increased to maximum of 25 ml/hr/site as tolerated

Maximum Infusion Rate: should NOT exceed a total of 50 ml/hr for all sites combined.

Possible Symptoms (RN to Monitor & 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 shortness of breath.

Patient Education:

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

Supplies:(will be dispensed based on SQIg dose and infusion rate)

- Freedom 60 pump, 60 ml syringe-BD, rate controlled tubing set, SQ needle set, transparent dressing/sterile gauze, alcohol pads, band aid, 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 prescription electronically or on official state prescription blank. Prescriber authorizes AcariaHealth to forward this prescription to another pharmacy, if needed. IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.