AcariaHealth
An envolve Pharmacy Solution

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

Phone: 866.506.2626 ● Fax: 800.696.0607

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

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ☐ M ☐ F	Weight:	☐ lbs. ☐ kg.	Height:
SSN:	Phone:	Allergies:				
Address:		City:	State:		Zip:	
Emergency Contact:		Phone:	☐ **Please attach demographic information**			

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: ☐ 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 ☐ g 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 _____
- **SQIg Home Training by RN (Certified for SQIg 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]

☐ **HyQvia** ☐ Ramping Required ☐ No Ramping Required
Dose Calculation: Week 1 dose (in gm) =0.25 x [previous IV / SQ monthly dose (gm)], Week 2 dose (in gm) =0.5 x [previous IV / SQ monthly dose(gm), Week 3: No Infusion, Week 4 dose (in gm) =0.75 x [previous IV / SQ monthly dose (gm), Week 5 & 6: No Infusion, Week 7 dose if needed (in g) = full previous dose IV / SQ monthly dose, then 3-4 weeks thereafter

Dose calculations based on every 3 weeks frequency,

- Week 1 Dose = 33% of the full dose
- Week 2 Dose = 66% of full dose

Week 3 Dose = 100% of 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 ☐ times per week ☐ Every _____
Qty: 4 weeks supply Refill: ___

Pharmacist to calculate: Previous Monthly SQ/IV Dose

HyQvia Ramp Up:

- Week 1 _____gm to be infused over _____hours into _____sites
- Week 2 _____gm to be infused over _____hours into _____sites
- Week 4 _____gm to be infused over _____hours into _____sites
- Week 7 _____ gm to be infused over _____hours into _____sites

HyQvia Maintenance Dose: **Note Frequency: Please specify if every 3 or 4 weeks.**

After initial ramp up: 300-600mg/kg q3-4 weeks gm to be infused over _____hours into _____sites_____Qty: 4 weeks supply Refills: ____

PRE-MEDICATIONS: To be Administered 30 Minutes Prior to SQ 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: ___

Please see second page

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

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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)

Cutaquig 16.5%
- First 6 infusions, rate at 15ml – 20ml per hour, per site. Subsequent infusion: Rate at 25ml per hour, per site up to total of 6 sites maximum.

Gammagard 10%: Conversions: Gammagard 10% dose ____gm x 10 = _____ml
- Infusion volume per site: If weight OVER 40 kg: 30 ml/site, if weight UNDER 40 kg: 20ml/site
- Maximum number of simultaneous sites: 8 infusion sites, at least 2 inches apart

Gamunex-C 10%: Conversions: Gamunex-C dose _gm **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_____gm **x 5** =_____ml
- Infusion volume per infusion site:
- FIRST infusion: up to 15 ml/site. AFTER 4th infusion: may increase to 20 ml/site (Maximum Volume: 25 ml/ site as tolerated)

HyQvia: Conversions: HyQvia-IG dose_____gm **x10** =_____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 body 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

Xembify 20%: Infusion Rate:_____ml/hr per site
- Maximum Infusion rate = or <25 ml/hr per site up to maximum of 6 sites at least 2" 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)
- FIRST infusion: 15ml/hr/site. SECOND 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, 50 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:**_____