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: 833.626.8417 ● Fax: 833.620.2725

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

PATIENT INFORMATION

Patient Name:	DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.
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❑ ❑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_____
- **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%** Order's increments: ❑10 ml (1 gr) ❑25 ml (2.5 gr) ❑50 ml (5 gr) ❑100 ml (10 gr) ❑200 ml (20 gr) ❑300 ml (30gr)
Dose Calculation: Initial weekly dose (in gr) =1.37 x [previous IVIG dose (gr) / number of weeks between IVIG doses]
❑**Gamunex-C 10%** Order's increments: ❑10 ml (1 gr) ❑25 ml (2.5 gr) ❑50 ml (5 gr) ❑100 ml (10 gr) ❑200 ml (20 gr) ❑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]
❑**Hizentra 20%** Order's increments: ❑5 ml (1 gr) ❑10 ml (2 gr) ❑20 ml (4 gr) ❑ 50 ml (10 gr)
❑**Hizentra 20%** Prefilled Syringe: ❑5ml (1 gr) ❑10ml (2 gr) ❑20ml (4 gr)
Dose Calculation: Initial weekly dose (in gr) =1.37 x [previous IVIG dose (gr) / number of weeks between IVIG doses]
❑**HyQvia** Order's increments: IG- ❑25 ml (2.5 gr) ❑50 ml (5 gr) ❑100 ml (10 gr) ❑200 ml (20 gr) ❑300 ml (30 gr)
Order's increments: HY-❑1.25 ml (2.5 gr) ❑2.5 ml (5 gr) ❑ 5 ml (10 gr) ❑10 ml (20 gr) ❑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 ❑Weekly ❑ times per week ❑Every _____
Qty: 4 weeks supply Refill: ___

Pharmacist to calculate: Previous Monthly SQ/IV Dose
HyQvia Ramp Up:

- 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)

❑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

- Benadryl 25 - 50 mg IVP every 4 hours prn (Rate not to exceed 25 mg/min) 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.

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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)

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 **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 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:**_____

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