



SQLg Infusion

Ph: (214) 919-2090 or (877) 753-6878

Fax: 1 (888) 294-9434

Injection Training: MD Office
 Pharmacy to Arrange

Ship To: Patient Home MD Office

MAIN POINT OF CONTACT

Name: _____

Phone: _____

PATIENT INFORMATION (Use this area or attach patient demographics)

Name: _____ Phone: _____ Phone 2: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

DOB: _____ SSN: _____ Sex: Male Female Height: _____ Weight: _____ lbs.

Emergency Contact: _____ Phone: _____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance: _____ Secondary Insurance: _____

ID#: _____ RxBin: _____ ID#: _____ RxBin: _____

RxGroup: _____ Pcn: _____ RxGroup: _____ Pcn: _____

DIAGNOSIS INFORMATION/MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

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 SQI infusion: Yes No

If Yes, was patient on IVIG infusion?

Yes, Last infusion date _____ Last infusion dose and frequency _____

No, igA level is more tht 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: 10ml (1 g) 25ml (2.5 g) 50ml (5 g) 100ml (10 g) 200ml (20 g) 300ml (30 g)

Dose Calculation: initial weekly dose (in grams) = **1.37x** [previous IVIG dose (grams)/number of weeks between IVIG doses]

Gamunex-C 10% Order's increments: 10ml (1 g) 25ml (2.5 g) 50ml (5 g) 100ml (10 g) 200ml (20 g) 400ml (40 g) latex free

Dose Calculation: Initial weekly dose (in grams) = **1.37x** [previous IVIG dose (grams)/number of weeks between IVIG doses]

Hizentra 20% Order's increments: 5ml (1g) 10ml (2g) 20ml (4g) 50ml (10g)

Dose Calculation: Initial weekly dose (in grams) = **1.37x** [previous IVIG dose (grams)/number of weeks between IVIG doses]

HyQvia Order's increments: IG: 25ml (2.5g) 50ml (5g) 100ml (10g) 200ml (20 g) 300ml (30g)

Order's increments: HY: 1.25ml (2.5g) 2.5ml (5g) 5ml (10g) 10ml (20g) 15ml (30g)

Dose Calculation: Week 1 dose (in grams) = **0.25x** [previous IV/SQ monthly dose (grams)], Week 2 dose (in grams) = **0.5x** [previous IV/SQ monthly dose (grams), Week 3: No Infusion, Week 4 dose (in grams) = **0.75x** [previous IV/SQ monthly dose (grams), Week 5&6:

No infusion, Week 7 dose if needed (in grams) = full previous dose IV/SQ monthly dose, then a 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: _____ grams (_____ 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 _____ grams to be infused over _____ hours into _____ sites

• Week 2 _____ grams to be infused over _____ hours into _____ sites

• Week 4 _____ grams to be infused over _____ hours into _____ sites

• Week 7 _____ grams to be infused over _____ hours into _____ sites

HyQvia Maintenance Dose:

After initial ramp up: 300-600mg/kg q3-4 weeks _____ grams to be infused over _____ hours into _____ sites Qty: 4 weeks supply Refill: _____

PRE-MEDICATION: To be Administered 30 minutes prior to SQ Infusion (optional)

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

PROCEDURE FOR ACUTE HYPERSENSITIVITY AND/OR ANAPHYLAXIS

STOP Infusion and call 911 and MD

• Benadryl 25-50 mg IVP every 4 hours pm (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: _____

Prescriber Name: _____ NPI#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

*Prescriber Signature: _____ Date: _____

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