MAIN POINT OF CONTACT

Name:_____

Phone:_____

ASP CARES

SQIg 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

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 neede (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:_____**

Please fax completed form to 1 (888) 294-9434