Subcutaneous Immune Globulin (SCIG) Order Form

Patient Information

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Birth</th>
<th>Name</th>
</tr>
</thead>
</table>

MRN #: ____________________________

I certify the following information is up to date in patient’s chart: demographics, medication list, allergies

Physician Information

<table>
<thead>
<tr>
<th>DEA #</th>
<th>NPI</th>
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| Telephone: |

Clinical Information

ICD-10 immunology: □ D80.0 Congenital Hypogammaglobulinemia □ D83.9 CVID (unspecified) □ D81.9 SCID (unspecified)

ICD-10 neurology: □ G61.81 CIDP □ G61.82 MMN □ G35 MS (rel remit) □ G61.0 GBS □ G70.01 MG

ICD-10 rheumatology: □ M33.20 Polymyositis □ M33.90 Dermatomyositis

Other: ____________________________

Other drugs used to treat the disease: ____________________________________________

Has the Patient Received IVIG Previously? □ Yes □ No Product: ________________________

Ht: _______ cm/in Wt: _______ kg/lbs Date: ___________

Attach patient demographics, insurance information, and medication list.

Attaching Clinical Documentation

- Primary Immune Deficiency - H&P, documented infection history/treatment, Pre-treatment and current IgG, IgA, IgM, and lg subclass serum levels.
- Neuromuscular Disorders – H&P (diagnosis of disorder must be unequivocal), documentation that other causes of demyelinating neuropathy have been excluded. For Myasthenia Gravis – tensilon test results and 6 month trial of corticosteroids.
- Rheumatology - H&P, creatine phosphokinase values, electromyography and/or muscle biopsy results

Immune Globulin Prescription

Preferred Product: __________________________ - Infuse _______ grams or _______ grams per kg subcutaneously every ______ week(s) or days

Infuse total dose of immune globulin subcutaneously in 1 to multiple sites via infusion pump as tolerated. Infusion rates per manufacturer recommendation, as tolerated.

Quantity/Refills: Dispense 1 month supply. Refill x 1 year unless noted otherwise.

Dispense: Sizes & quantities sufficient Round to nearest vial size as clinically appropriate

Other Instructions:

Premedication to be given 30 minute prior to infusion:

- □ Diphenhydramine 25mg by mouth (contraindicated in myasthenia gravis) □ Acetaminophen 650mg by mouth
- □ Other: __________________________

Medications to be used as needed: (please strike through if not required)

- □ Diphenhydramine 25mg by mouth every 4–6 hours as needed for mild infusion reactions, may increase to 50mg for moderate to severe; maximum of 4 doses per day (contraindicated in patients with myasthenia gravis)
- □ Acetaminophen 650mg by mouth every 4–6 hours as needed for fever, headache or chills; maximum of 4 doses per day

Adverse reaction medications: (keep on hand at all times)

- □ Epinephrine 0.3mg auto-injector 2-pk for patients weighing greater than or equal to 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose

Supplies: (please strike through if not required)

- □ Dispense needles, syringes and home medical equipment necessary to administer medication.

Nursing Services: (please strike through if not required)

- □ Skilled nursing visits to educate patient on subcutaneous access, medication administration, use of supplies, therapy and disease state and to assess general status and response to therapy; patient discharged from nursing once teaching complete.

Other Orders (i.e. Labs):

- □ I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient’s treatment

Prescribers Signature: __________________________ Date: __________________________

Office Contact: __________________________ Phone: __________________________

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