HEALTH CARE MEDICAL
Infusion Specialties
An Access Infusion Care Company

SUBCUTANEOUS IMMUNOGLOBULIN ORDERS

REFERRAL CHECKLIST
Please ensure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ Include recent CBC w/diff, CMP, quantitative immunoglobulins, lymphocyte subset panel if applicable
☐ Completed and Signed Referral
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

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Print, complete, and fax completed form to (769) 233-8051

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PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Ht: Wt: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ **New Referral** ☐ **Continuation Order** ☐ **Dose or Frequency Change**

First dose? ☐ Yes ☐ No - Date of last infusion:

DIAGNOSIS

☐ Dx Code/description: | ☐ Secondary Dx Code/description:

REQUIRED DOCUMENTATION ☐ **Signed order** ☐ **Demographics and insurance info** ☐ **H&P, labs, tests, progress notes supporting dx**

- Prior Therapies:

☐ Recent IgG level result (PID,CVID Dx):

PRESCRIBING INFORMATION

LAB ORDERS

Frequency: Every Labs: ☐ CMP ☐ CBCwdif ☐ CRP ☐ Sed Rate ☐ IgA, IgG, IgM panel ☐ Lymphocyte subset panel

☐ Other:

PREMEDICATIONS (administer 30 minutes prior to infusion)

Acetaminophen: ☐ 650mgPO ☐ 1000mgPO | Methylprednisolone: ☐ 100mgIV ☐ 125mgIV ☐ mgIV

Diphenhydramine: ☐ 25mgPO ☐ 50mgPO ☐ 25mgIV ☐ 50mgIV | Other: ☐

MEDICATION

Medication	Dose/Strength	Directions	Quantity
☐ **Cutaquig** ☐ **Hizentra** ☐ **Xembify** ☐ **Other:**	☐ mg/kg ☐ gm	☐ Weekly ☐ Every weeks ☐ Every Infuse subcutaneously, follow infusion rates per product PI	☐ #sufficient for weight-based dose Refills:

Use current documented weight;
Round calculated dose to the nearest dose achievable using whole vials of one available vial size within ±10% of the calculated dose.
If not specified, order will be valid for 1 year from the date of signature.

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:Use 50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain SpO_2 95-100%.

Prescriber Signature X: _____ **Date:** _____

☐ **Product Substitution Permitted** ☐ **Dispense as Written**

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