

Subcutaneous Immunoglobulin (SCIG) | Order Form

Patient Name: _____ DOB: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____

1. For new patients, please submit with form:

- Copy of insurance card ● Demographics ● History & physical ● Labs, please include results supporting diagnosis
- Baseline assessment (include medications tried and failed, if any)

2. Patient Information

Male Female Height: _____ in cm Weight: _____ lbs kg Allergies: _____

History of immunoglobulin (IG) therapy: Is patient new to SCIG? Yes No (If known, please indicate date next delivery is needed by: _____)

Is patient switching from IVIG to SCIG? Yes* No *If yes, target SCIG start date to be 1 week after final dose of IVIG unless otherwise specified

Other information: _____

3. Diagnosis and Clinical Information

ICD-10 (required): _____ Primary diagnosis (or check below):
 CIDP Congenital hypogammaglobulinemia CVID Dermatomyositis Guillain-barré syndrome
 Multifocal motor neuropathy Multiple sclerosis Myasthenia gravis Polymyositis SCID

4. Prescription Information

SCIG Product	<input checked="" type="checkbox"/> SCIG: pharmacist to select product based on patient specific factors and notify provider of selection Specific SCIG product required (list product): _____
Optional IVIG Loading Dose	IVIG – Product: Unbranded (pharmacist to select product) or Brand required: Administer _____ grams OR _____ grams/kg* IV divided over _____ day(s) one time Other: _____
SCIG Maintenance Dose	SCIG Dose: _____ grams OR _____ grams/kg* (rounded to nearest whole vial size) *If weight is >130% ideal body weight (IBW), use adjusted body weight (IBW+0.4[ABW-IBW]) to calculate dose Frequency: Weekly Every 2 weeks Other: _____
SCIG Administration	<input checked="" type="checkbox"/> Infuse subcutaneously via infusion pump, using 1 or more sites, adjusted as tolerated per manufacturer guidelines OR may specify: infuse in _____ site(s) using _____ rate flow tubing over _____ minutes Other: _____
Quantity / Refills	Dispense 1 month supply / Refill x 12 months Other: _____ Dispense all medical supplies necessary for infusion

5. Additional Orders

- For IV loading dose (if ordered): RN to start peripheral IV or existing CVC. RN to administer catheter flushing per PromptCare Policy and Procedure. RN may instruct patient to hydrate pre/post infusion and educate on taking **OTC diphenhydramine and/or acetaminophen** per manufacturer dosing recommendations as needed to prevent/treat post-infusion headache.
 Skilled nursing services to be provided for infusion, assessment and teaching of SCIG as needed
 Other: _____

6. Adverse Reaction Orders

For SCIG: Prescriber to send separate prescription to retail pharmacy of patient's choice for epinephrine pen, for use in anaphylactic reaction

- For IVIG **only** (if ordered): Standard anaphylaxis kit to be dispensed and dosed per protocol: Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL vial), and NS IV. Other: _____

7. Prescriber Information

Prescriber Name: _____ Office Contact: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 License #: _____ DEA #: _____ NPI: _____

 Physician Signature (Substitution Permitted)

 Date

 Physician Signature (Dispense as Written)

 Date

By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. PromptCare has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.

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