promptcare

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C-2024

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	☒ **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	☒ 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.