

## 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

<b>SCIG Product</b>	<input checked="" type="checkbox"/> <b>SCIG:</b> pharmacist to select product based on patient specific factors and notify provider of selection Specific SCIG product required (list product): _____
<b>Optional IVIG Loading Dose</b>	<b>IVIG – Product:</b> Unbranded (pharmacist to select product) or Brand required: Administer _____ grams <b>OR</b> _____ grams/kg* IV divided over _____ day(s) one time <b>Other:</b> _____
<b>SCIG Maintenance Dose</b>	SCIG Dose: _____ grams <b>OR</b> _____ 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: _____
<b>SCIG Administration</b>	<input checked="" type="checkbox"/> Infuse subcutaneously via infusion pump, using 1 or more sites, adjusted as tolerated per manufacturer guidelines <b>OR</b> may specify: infuse in _____ site(s) using _____ rate flow tubing over _____ minutes <b>Other:</b> _____
<b>Quantity / Refills</b>	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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