

| PATIENT INFORMATION                                          |              | PRESCRIBER INFORMATION  |  |
|--------------------------------------------------------------|--------------|-------------------------|--|
| Patient Name: _____                                          |              | Prescriber Name: _____  |  |
| Address: _____                                               |              | NPI: _____              |  |
| City, State, Zip: _____                                      |              | Address: _____          |  |
| Cell: _____                                                  | Email: _____ | Email: _____            |  |
| Height _____ Weight _____ kg Last 4 of SSN: _____ DOB: _____ |              | City, State, Zip: _____ |  |
|                                                              |              | Phone: _____ Fax: _____ |  |
| Allergies: _____                                             |              | Contact Person: _____   |  |

| REFERRAL STATUS                                   |                                                                                                    |
|---------------------------------------------------|----------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> New Referral             | First dose? <input type="checkbox"/> Yes <input type="checkbox"/> No - Date of last infusion _____ |
| <input type="checkbox"/> Dose or Frequency Change |                                                                                                    |
| <input type="checkbox"/> Continuation Order       |                                                                                                    |

| DIAGNOSIS                                                                                |                                                                                     |
|------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| <input type="checkbox"/> D80.6 Primary Immunodeficiency (PID)                            | <input type="checkbox"/> D83.9 Common variable immunodeficiency, unspecified (CVID) |
| <input type="checkbox"/> G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) | <input type="checkbox"/> G61.82 Multifocal Motor Neuropathy (MMN)                   |
| <input type="checkbox"/> Other ICD-10 CODE: _____                                        |                                                                                     |

| REQUIRED DOCUMENTATION                                                                                                                                                                                                  |                                                                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>This signed order form by the provider</li> <li>Patient demographics and insurance information</li> <li>H&amp;P, labs, tests, and progress notes supporting diagnosis</li> </ul> | <ul style="list-style-type: none"> <li>Prior Therapies: _____</li> <li>Most recent serum IgG level if PID or CVID: _____</li> </ul> |

| PRESCRIBING INFORMATION                                                                                                                                                                                                                                |                                               |                                                                  |                                    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|------------------------------------------------------------------|------------------------------------|
| Medication                                                                                                                                                                                                                                             | Dose/Strength                                 | Directions                                                       | Quantity                           |
| <input type="checkbox"/> Cutaquig                                                                                                                                                                                                                      | <input type="checkbox"/> _____ mg/kg per dose | <input type="checkbox"/> Infuse subcutaneously every _____ days  | Qty: sufficient for dose per month |
| <input type="checkbox"/> Cuvitru                                                                                                                                                                                                                       | <input type="checkbox"/> _____ gm per dose    | <input type="checkbox"/> Infuse subcutaneously every _____ weeks | Refill: _____                      |
| <input type="checkbox"/> Hizentra                                                                                                                                                                                                                      |                                               |                                                                  |                                    |
| <input type="checkbox"/> Xembify                                                                                                                                                                                                                       |                                               |                                                                  |                                    |
| <input type="checkbox"/> Other _____                                                                                                                                                                                                                   |                                               |                                                                  |                                    |
| <b>PREMEDICATIONS (administer 30 minutes prior to infusion)</b>                                                                                                                                                                                        |                                               |                                                                  |                                    |
| <input type="checkbox"/> Acetaminophen: <input type="checkbox"/> 650 mg PO <input type="checkbox"/> 1000 mg PO                                                                                                                                         |                                               |                                                                  |                                    |
| <input type="checkbox"/> Diphenhydramine: <input type="checkbox"/> 25 mg PO <input type="checkbox"/> 50 mg PO <input type="checkbox"/> 25 mg IV <input type="checkbox"/> 50 mg IV                                                                      |                                               |                                                                  |                                    |
| <input type="checkbox"/> Methylprednisolone: <input type="checkbox"/> _____ mg IV <input type="checkbox"/> 100 mg IV <input type="checkbox"/> 125 mg IV                                                                                                |                                               |                                                                  |                                    |
| <input type="checkbox"/> Lab Work every _____ <input type="checkbox"/> CMP <input type="checkbox"/> CBC w dif <input type="checkbox"/> CRP <input type="checkbox"/> Sed Rate <input type="checkbox"/> Immunoglobulins A, G, M subset panel lymphocytes |                                               |                                                                  |                                    |
| <input type="checkbox"/> _____                                                                                                                                                                                                                         |                                               |                                                                  |                                    |

PIV: Flush with 3–10 mL of 0.9% sodium chloride before and after the infusion  
 PICC/Midline: Flush 10 mL 0.9% NS before/after, then 3 mL Heparin 10 units/mL final flush  
 Port: Flush 10 mL 0.9% NS before/after, then 5 mL Heparin 100 units/mL final flush  
 Post-Infusion: Use 50 ml 0.9% NS bag to flush residual priming volume

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline  
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration  
 RN to flush and lock VAD/CVAD per company protocol

| EMERGENCY MEDICATION                                                                                                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Administer the following medications as needed for infusion-related reactions per company protocol:                                                                                                                                                                       |
| <b>Adults (&gt;40 kg):</b> Diphenhydramine 25–50 mg PO or IV slow push (2–5 min); Acetaminophen 325–650 mg PO; Methylprednisolone 125 mg IV slow push (≥5 min); Epinephrine 0.3 mg IM/SQ, may repeat ×1; 0.9% NS 500 mL IV over 30–60 min, may repeat ×1 for hypotension. |

**Pediatrics and Adults under (<40 kg):** Diphenhydramine 25 mg PO or IV slow push (2–5 min); Acetaminophen 325 mg PO; Methylprednisolone 40 mg IV slow push (≥5 min); Epinephrine 0.15 mg (<30 kg) or 0.3 mg (>30 kg) IM/SQ, may repeat ×1; 0.9% NS 500 mL IV over 30–60 min, may repeat ×1 for hypotension.

**Oxygen (AIC/AIS only):** 1–6 L/min via NC or face mask; titrate to maintain SpO<sub>2</sub> 95–100%.

Prescriber Signature X: \_\_\_\_\_

X: \_\_\_\_\_

Product Substitution Permitted: \_\_\_\_ Date: \_\_\_\_\_

Dispense as Written: \_\_\_\_ Date: \_\_\_\_\_