BIG SKY IV CARE
Infusion Pharmacy & Nursing
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.<br>Thank you! |

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# SUBCUTANEOUS IMMUNOGLOBULIN ORDERS

| 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**<br>☐ **Hizentra**<br>☐ **Xembify**<br>☐ **Other:** | ☐ mg/kg<br>☐ gm | ☐ Weekly<br>☐ Every weeks<br>☐ Every<br>Infuse subcutaneously, follow infusion rates per product PI | ☐ #sufficient for weight-based dose<br>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<br>Post-Infusion:Use 50ml0.9%NS to flush residual priming volume | PIV:Flush 3-10mL0.9%NS before/after<br>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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