AcariaHealth
Specialty Pharmacy

Date Shipment Needed: _____ Ship To: ❑Patient ❑Prescriber
❑Nursing needed ❑Training needed ► All the supplies including syringes and needles will be dispensed if needed.

Phone: 866.506.2626 ● Fax: 800.696.0607

SUBCUTANEOUS IMMUNE GLOBULIN (SQIg) INFUSION REFERRAL FORM (2 Pages)

PATIENT INFORMATION					
Patient Name:		DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	❑ **Please attach demographic information**		

INSURANCE INFORMATION
❑ **Please attach front and back of patient's insurance card (medical and prescription)**

PRESCRIBER INFORMATION			
Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:	Practice Name:		
Address:	City:	State:	Zip:
Phone: Fax:	Key Office Contact:	Phone:	

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Diagnosis: ❑Primary Immunodeficiency (PI) ❑Other:_____

Treatment Setting & Patient Training:

Initial Treatment Setting: ❑Patient's Home ❑Physician Office ❑Outpatient Clinic ❑Inpatient
Final Treatment Setting: ❑Patient's Home ❑Physician Office ❑Outpatient Clinic ❑Inpatient

- **First SQIg infusion:** ❑Yes ❑No If yes, was patient on IVIG infusion?
  - ❑ Yes, Last infusion Date____/____/_____Last infusion dose and frequency _____
  - ❑ No, IgA level is more than 5 mg/dl: ❑Yes ❑No ❑Not Available❑ ❑Ig Quantitation: IgA, IgG, IgM (prior to 1st IVIG infusion)
- **Labs**: To be monitored by MD prior to infusion and again at appropriate intervals thereafter: ❑CBC with Differential ❑Basic Metabolic Panel (BMP) ❑Other_____
- **SQIg Home Training by RN (Certified for SQIg infusion):** First SQIg infusions to be administered by RN ❑Yes ❑No

IMMUNE GLOBULIN SUBCUTANEOUS "HUMAN" ORDER: (will dispense available increment)

❑**Gammagard 10%** Order's increments: ❑10 ml (1 gr) ❑25 ml (2.5 gr) ❑50 ml (5 gr) ❑100 ml (10 gr) ❑200 ml (20 gr) ❑300 ml (30gr)
Dose Calculation: Initial weekly dose (in gr) =1.37 x [previous IVIG dose (gr) / number of weeks between IVIG doses]
❑**Gamunex-C 10%** Order's increments: ❑10 ml (1 gr) ❑25 ml (2.5 gr) ❑50 ml (5 gr) ❑100 ml (10 gr) ❑200 ml (20 gr) ❑400 ml (40 gm) latex free
Dose Calculation: Initial weekly dose (in gr) =1.37 x [previous IVIG dose (gr) / number of weeks between IVIG doses]
❑**Hizentra 20%** Order's increments: ❑5 ml (1 gr) ❑10 ml (2 gr) ❑20 ml (4 gr) ❑ 50 ml (10 gr)
❑**Hizentra 20%** Prefilled Syringe: ❑5ml (1 gr) ❑10ml (2 gr) ❑20ml (4 gr)
Dose Calculation: Initial weekly dose (in gr) =1.37 x [previous IVIG dose (gr) / number of weeks between IVIG doses]
❑**HyQvia** Order's increments: IG- ❑25 ml (2.5 gr) ❑50 ml (5 gr) ❑100 ml (10 gr) ❑200 ml (20 gr) ❑300 ml (30 gr)
Order's increments: HY-❑1.25 ml (2.5 gr) ❑2.5 ml (5 gr) ❑ 5 ml (10 gr) ❑10 ml (20 gr) ❑15 ml (30 gr)
Dose Calculation: Week 1 dose (in gr) =0.25 x [previous IV / SQ monthly dose (gr)], Week 2 dose (in gr) =0.5 x [previous IV / SQ monthly dose(gr), Week 3: No Infusion, Week 4 dose (in gr) =0.75 x [previous IV / SQ monthly dose (gr), Week 5 & 6: No Infusion, Week 7 dose if needed (in g) = full previous dose IV / SQ monthly dose, then 3-4 weeks thereafter

DOSAGE: (will use available increment / combination of vial sizes for each dose. Each dose will be rounded to next vial size).

Dosage:_____gr (_____ml) to be infused subcutaneously over _____hours as tolerated ❑Weekly ❑ times per week ❑Every _____
Qty: 4 weeks supply Refill: ___

Pharmacist to calculate: Previous Monthly SQ/IV Dose
HyQvia Ramp Up:

- Week 1 _____gr to be infused over _____hours into_____sites
- Week 2 _____gr to be infused over _____hours into_____sites
- Week 4 _____gr to be infused over _____hours into_____sites
- Week 7 _____ gr to be infused over _____hours into_____sites

HyQvia Maintenance Dose:
After initial ramp up: 300-600mg/kg q3-4 weeks gr to be infused over _____hours into _____sites_____Qty: 4 weeks supply Refills: _

PRE-MEDICATIONS: To be Administered 30 Minutes Prior to SQ Infusion(Optional)

❑Diphenhydramine 25 – 50 mg PO QTY: #2 (25 mg) ❑ Acetaminophen 650 mg PO QTY: #2 (325 mg) ❑Other_____QTY: QS

Procedure for Acute Hypersensitivity and/or Anaphylaxis

STOP Infusion and call 911 & MD

- Benadryl 25 - 50 mg IVP every 4 hours prn (Rate not to exceed 25 mg/min) □ to be administered by a nurse QTY: 3 (50 mg)
- Epipen (adult) 0.3 mg IM x 1, may repeat QTY: 3
- Other:_____ QTY:___

Please see second page

Prescriber's Signature: _____ ❑ DAW (Dispense as Written) **Date:**_____

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Instructions for SQIg Administration

- SQIg Home Training by RN (Certified for SQIg infusion): First SQIg infusions to be administered by RN
- Obtain baseline vital signs (T,P,R,BP)
- Vital signs every 15 minutes for the 1st hour, then every 30 minutes for the remainder of infusion
- Assure that patient is not volume depleted prior to initiation of SQIg infusion.

Number of Simultaneous Injection Sites

Number of simultaneous infusion sites: ____

SQ needle set: ❑Single lumen (1) ❑Bifurcated (2) ❑Trifurcated (3) ❑Quadfurcated (4) ❑Pentafurcated (5) ❑Hexafurcated (6)
(based no max number of injections per site may need to use combination of SQ needle set)

Gammagard 10%: Conversions: Gammagard 10% dose ___gr x 10 = _____ml

- Infusion volume per site: If weight more than 40 kg: 30 ml/site
- If weight less than 40 kg: 20ml/site
- Maximum number of simultaneous sites: 8 infusion sites, at least 2 inches apart

Gamunex-C 10%: Conversions: Gamunex-C dose__gr **x 10** =_ml

- Infusion volume per site (recommended mean volume): 34 ml/site
- Maximum number of simultaneous sites: 8 infusion sites, at least 2 inches apart

Hizentra 20%: Conversions: Hizentra dose_____gr **x 5** =_____ml

- Infusion volume per infusion site:
- First infusion: up to 15 ml/site
- After the 4th infusion: may increase to 20 ml/site (Maximum Volume: 25 ml/ site as tolerated)

HyQvia: Conversions: HyQvia-IG dose_____gr **x10** =_____ml HyQvia-HY dose_____gr **/2** =___ml

- Infusion volume per infusion site (Maximum of 2 sites allowed but have to be on opposite sides of the ody in abdomen or thigh): 1st site if ≥ 40 kg = 600 ml/site and 1st site if < 40 kg = 300 ml/site 2nd site is used then administer ½ the total volume in each site = 300 ml/site if ≥ 40 kg and 150 ml/site if < 40 kg. Maximum number of simultaneous sites: 4 infusion sites, at least 2 inches apart

Gammagard 10% Infusion Rate:_____ml/hr per site as tolerated (please indicate if different than suggested infusion rate)

- Initial Infusion Rate: If weight is more than 40 kg: 20 ml/hr/site OR If weight is less than 40 kg: 15 ml/hr/site
- Maximum Infusion Rate: If weight more than 40 kg: 30 ml/hr/site (OR: maximum infusion rate 240 ml/hr for all sites combined) If weight less than 40 kg: 20 ml/hr/site (OR: maximum infusion rate 160 ml/hr for all sites combined)

Gamunex-C 10% Infusion Rate:_____ml/hr per site as tolerated (please indicate if different than suggested infusion rate)

- Suggested Infusion rate: 20 ml/hr per site

Hizentra 20% Infusion Rate:_____ml/hr per site as tolerated (please indicate if different than suggested infusion rate)

- 1st infusion: 15ml/hr/site
- 2nd and subsequent infusions: if no reaction may be increased to maximum of 25 ml/hr/site as tolerated

Maximum Infusion Rate: should NOT exceed a total of 50 ml/hr for all sites combined.

Possible Symptoms (RN to Monitor & Train Patient): Discontinue Infusion and Notify MD if:

- Malaise, chest tightness, a feeling of faintness, dyspnea, fever/chills, chest / back or hip pain, nausea/ vomiting, mild erythema, hypotension/ hypertension, headache, fatigue, leg cramps, lightheadedness, fever, urticaria, flushing AMS (aseptic meningitis syndrome)
- Stop the infusion and notify MD ASAP
- Patient should be instructed to report symptoms of decreased urine output, sudden weight gain, fluid retention, and shortness of breath.

Patient Education:

- RN to educate/train patient on SQ-infusion
- RN to educate patient on the possible adverse reactions including: Injection site reaction (i.e., swelling, redness, heat, pain, and itching at the injection site), headache, vomiting, pain, fatigue.

Supplies:(will be dispensed based on SQIg dose and infusion rate)

- Freedom 60 pump, 60 ml syringe-BD, rate controlled tubing set, SQ needle set, transparent dressing/sterile gauze, alcohol pads, band aid, gloves, sterile towel drape, sharps container.

Prescriber's Signature: _____ ❑ DAW (Dispense as Written) **Date:**_____