

Subcutaneous Immunoglobulin (SCIG) | Order Form

Patient Name:

Address:

DOB:

Phone:

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	<input checked="" type="checkbox"/> 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 Administer grams OR grams/kg* IV divided over Other:	Brand required:	day(s) one time
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	<input checked="" type="checkbox"/> 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 Coastal Infusion Services 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 Name:

Address:

Phone:

License #:

Office Contact:

City:

State:

Zip:

Fax:

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. Coastal Infusion Services 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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