COASTAL INFUSION SERVICES

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Madisonville, LA 70447
Local: 985-792-9001
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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

SCIG Product	☒ **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 ☐Brand required: _____ Administer _____ grams **OR** _____ grams/kg* IV divided over _____ day(s) one time **Other**: _____
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	☒ 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 s**eparate 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: _____ 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. 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.