Immunology IVIG & Sub-Q **Fax: 833-808-0833**

Patient Information

Patient Name: ________________________ DOB: ___________ Height: _____ Patient Contact #: ______________

Medical Assessment: Diagnosis (ICD-10):

☐ Common Variable Immune Deficiency (D83.9)
☐ Common Immunity Deficiency & SCID (D80.4)
☐ Congenital Hypogammaglobulinemia (D80.0)
☐ Hypogammaglobulinemia (D80.1)
☐ Immunodeficiency with Increased IgM (D80.5)
☐ Immunodeficiency with Predominant T-Cell Defect (D83.1)
☐ Selective IgA Immunodeficiency (D80.2)
☐ Selective IgM Immunodeficiency (D80.4)
☐ Other Selective Immunodeficiency (D80.3)
☐ Wiscott – Aldrich Syndrome (D82.0)
☐ Other: ____

Allergies: ____

Pre-Medication Orders:

- ❑ APAP □ 325mg □ 500mg □ 650mg - PO 30 minutes before infusion.
- ❑ Diphenhydramine □ 25mg □ 50mg – PO 30 minutes before infusion.
  □ 25mg IVP □ 50mg IVP
- ❑ Alternate Oral Antihistamines: □ Cetirizine 10mg □ Loratadine 10mg □ Fexofenadine 60mg or □180mg
- ❑ Methylprednisolone □ 40mg IVP □ 125mg IVP or other ____ mg IVP
- ❑ Famotidine □ 20mg PO □ 40mg PO □ 20mg IVP □ 40mg IVP
- ❑ Ondansetron □ 4 mg IVP □ 4 mg PO

Labwork: ________________________________To by Drawn by: ☐ Infusion Clinic ☐ Referring Provider

Medication: **Patient's Current Weight: ______ lbs**

Administer IVIG Product: ☐ **AIC to Determine (or)** ☐ **Brand:** ____________________________

□ Loading Dosage: Infuse _____ grams /kg via pump over _____ days.
□ Maintenance Dosage: Infuse ______ grams/kg via pump every ________ weeks **Refills:** _______
□ Other Regimen: ________________________________

Cutaquig

□ **Infuse** ______ grams via Freedom 60 pump every week. **Refills:** _______
□ Other Regimen: __________________________________

Hizentra

□ Infuse ______ grams via Freedom 60 pump every week. **Refills:** _______
□ Other Regimen: ________________________________

Hyqvia

□ Induction: Infuse _____ total grams SQ per induction protocol.

***** Administration of Induction Dosage in AIC / HCP office only*****

		□ Frequency – Every 4 Weeks	□ Frequency – Every 3 Weeks
1st Infusion	Week 1	Grams x 0.25	Grams x 0.33
2nd Infusion	Week 2	Grams x 0.5	Grams x 0.67
3rd Infusion	Week 4	Grams x 0.75	Administer Total grams
4th Infusion	Week 7	Administer Total Grams	N/A

□ Maintenance: Infuse ____ total grams every ____ weeks. **Refills:** _______

**** Maintenance Hyqvia Dosage to Infuse: □ in AIC / HCP Office □ Home Infusion Provider (transfer) ****

Physician Prescription Orders Address: ____ Phone: _______________

Fax: ______________________ Clinic Contact: ____________________Physician Name: ___________________________________

NPI #__________________________ ***Physician Signature:*** ___________________________________ ***Date:*** _______________