Specialty Care Rx
Excellence is Our Specialty

Specialty Care Infusion Center
Care for life

□ **Orange, CA**
P: (714) 941-6177 F: (714) 941-6178

□ **Burbank,CA**
P: (818) 848-8112 F: (818) 848-8142

□ **Las Vegas, NV**
P: (702) 825-4900
F: (702) 977-8150

□ **Las Vegas, NV**
P: (702) 790-4404 F: (702) 790-4406

□ **Marrero, LA**
P: (504) 340-5221 F: (504) 340-5228

□ **Allen, TX**
P: (469) 257-4200 F: (469) 795-9204

□ **Memphis, TN**
P: (901) 560-3580 F: (901) 560-3581

□ **Carson City, NV**
P: (702) 825-4900
F: (702) 977-8150

IV/SQ Ig Referral Form

Patient Information

Patient Name: _____ DOB: __/__/____
Sex: □ Femal □ Male SS#: ___-__-____ Language: _____
Allergies: _____ Wt: ____ □Kg □Lb Ht: ____ □Cm □In
Address: _____ Apt/Suite: _____
City: _____ State: _____ Zip: _____
Phone: _____ Contact: _____ Relation: _____
Email Address: _____

Prescriber Information

Prescriber Name: _____ NPI: _____
If Shipping to prescriber: □ Initial Fill □ Always □ Never
Address: _____ Apt/Suite: _____
City: _____ State: _____ Zip_____
Phone: _____ Contact: _____
Fax: _____ Alt. Fax: _____
Email Address: _____

INSURANCE INFORMATION (or attach copy of cards)

Medical Plan: _____ Policy #: _____ Policy Holder: _____ Relationship: _____
Prescription Plan: _____ Policy #: _____ Policy Holder: _____ Relationship: _____

Clinical Information

Access Type: □ Peripheral □ PICC □ PORT □ SCIG
Has patient previously been on IG therapy? □ No □ Yes/Brand Infused:_____/Last Infusion:_____
Comorbidities/Risk Factors: □ Renal Insufficiency □ Diabetes □ Heart Disease □ Thromobotic Event □ Hypertension
IgA deficiency: Yes No IgA level:_____mg/dL (Date:_____) Does patient have a latex allergy? □ Yes □ No
Previously Tried Treatments/Medications for The Condition: _____

Prescription

□ IVIG (Pharmacy to determine)
□ Cutaquig 16.5% (SC route)
□ Cuvitru 20% (SC route)
□ Gammagard Liq 10%
□ Gammagard S/D □5% □10%
□ Other: _____

□ Gammaked 10%
□ Gamunex-C 10%
□ Hizentra 20% □PFS □Vials (SC route)
□ HyQvia 10% (SC route)

□ SQIG (Pharmacy to determine)
□ Octagam 5% 10%
□ Panzyga 10%
□ Privigen 10%
□ Xembify 20% (SC route)

Dose and Frequency

□ Intravenous Immunoglobulin **□ Subcutaneous Immunoglobulin**

□ Loading Dose: ____ gm/kg Over ____ day(s) then
□ Maintenance Dose: ____ gm/kg Over ____ day(s), every ____ week(s) X ____ cycle(s)

□ 0.4 gm/kg □ 1 gm/kg □ 2 gm/kg
□ Infuse ____ grams IV daily X ___ day(s); repeat every week(s) X ___ cycle(s)
□ Other: _____

□ Infuse ____ grams OR ____mLs
using ___ sites X ___ time(s) per week
for ___ month(s)

Hydration and Pre-Medications

□ Hydration: NaCl 0.9% 250mL to infuse at a rate of 250mL/hr IV before & after infusion as hydration is needed.
□ Benadryl 25mg capsule: Take 1-2 caps by mouth 30-60 minutes prior to infusion & every 6 hours as needed post infusion.
□ Benadryl 50mg ampule: Infuse ____mg slow IVP 30 minutes prior to infusion
□ Tylenol 325mg: Take 1-2 tabs by mouth 30-60 minutes prior to infusion & every 6 hours as needed post infusion.
Not to exceed total daily dose of 3000mg.
□ Zofran 4mg ODT: Dissolve 1 tab on the tongue every 8 hours as needed for pre & post infusion for nausea and vomiting.
□ Solu-Cortef: Infuse _____mg slow IVP 30 minutes prior to infusion
□ Solu-Medrol: Infuse _____mg slow IVP 30 minutes prior to infusion

Flushing Protocol

□ Sodium Chloride 0.9% 5-10 ml pre and post medications
□ Heparin ____Units/mL OR ____mL as needed

Anaylaxis Protocol

MILD infusion reactions: (Slow infusion rate by 50% until symptoms resolve. Resume at previous rate as tolerated)
Diphenhydramine 25mg caps #4 Sig:Take 1-2 capsules PO Q6H PRN for infusion reactions, NTE total daily dose of 400mg (16 caps/day).
MODERATE infusion reactions: (Stop Infusion, resume at 50% rate when symptoms resolve)

Diphenhydramine 50mg/ml vial #1 Sig: Inject 1ml (=50mg) IV by slow IV push over 3-5 mins PRN for anaphylaxis reaction.
May repeat every 4 hrs, NTE 400mg/24hrs

SEVERE ANAPHYLAXIS *CALL 911* (Stop infusion and remove tubing from access device to prevent further administration)

1. Epinephrine 0.3mg Auto Injector #2 Sig: Remove cap then inject auto-injector intramuscularly in the thigh area and hold for 2 to 10 seconds as needed for anaphylaxis reaction, may administer through clothing if necessary. May repeat in 5-15-minutes.
2. Initiate 0.9% NaCl 500 mL IV x 1
3. Administer CPR if needed until EMS arrives

Ancillary Supplies : As needed for proper administration and disposal of medication

Skilled Nursing Visits: As needed for IV access, administration and proper clinical monitoring

Administration procedures to be followed per pharmacy protocol.

Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): _____

Deliver to: ☐ Home ☐ Office ☐ Infusion Suite ☐ Other: _____

If shipped to prescriber's office or infusion clinic, prescriber accepts on behalf of patient for administration in office or infusion clinic.
By signing this order, I, the prescriber, certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber's Signature _____ **Date: ___/___/_____**

* Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.
" Referral forms are not valid in Arizona, providers can phone or electronically send in orders."