SQIG INFUSION

Referral Phone: 800-622-9321
Referral Fax: 614-367-1684

DECILLION HEALTHCARE

Demographics

Last Name:	First Name:	Male/Female:	
Home Address:	City:	State:	Zip:
DOB:	Height:	Weight:	Allergies:
Phone (H):	Phone (C):	Phone (W):	
Email: _____ SSN #: _____			

**Complete and Attach Copies of card*

Insurance

Primary Insurance:	City:	State:	Phone:
Card Holder Name:	ID #:	Group #:	
Employer:	Prescription Card:	City:	State:	Phone:

Medical Necessity

Diagnosis (choose one): ☐ Primary Immunodeficiency (PI) ☐ Others:_____

Treatment Setting & Patient Training:

Step 1: Initial Treatment Setting: ☐ Patient's Home ☐ Physician Office ☐ Outpatient Clinic ☐ Inpatient

Step 2: 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 5mg/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

Prescription

Immune Globulin Subcutaneous "Human" Order: (will dispense available increment)

☐ **Gammagard 10%** Order's increments: ☐ 10 ml (1 gram) ☐ 25 ml (2.5 grams) ☐ 50 ml (5 grams) ☐ 100 ml (10 grams) ☐ 200 ml (20 grams) ☐ 300 ml (30 grams)

Dose Calculation: Initial weekly dose (in grams) = 1.37 x [previous IVIG dose (grams) / number of weeks between IVIG doses]

☐ **Gamunex-C 10%** Order's increments: ☐ 10 ml (1 gram) ☐ 25 ml (2.5 grams) ☐ 50 ml (5 grams) ☐ 100 ml (10 grams) ☐ 200 ml (20 grams)

Dose Calculation: Initial weekly dose (in grams) = 1.37 x [previous IVIG dose (grams) / number of weeks between IVIG doses]

Hizentra 20 % Order's increments: ☐ 5 ml (1 gram) ☐ 10 ml (2 grams) ☐ 20 ml (4 grams)

Dose Calculation: Initial weekly dose (in grams) = 1.53 x [previous IVIG dose (grams) / number of weeks between IVIG doses]

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

Dosage: _____grams (_____ml) to be infused subcutaneously over____ hours as tolerated ☐ Weekly ☐ _____ times per week ☐ Every_____

Qty: 4 weeks supply Refill: _____

Pharmacist to calculate: Total dose to be infused simultaneously* into ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or _____ subcutaneous sites via a pump.

(Rotate sites of injections to maintain skin health)

**Note: Total dose may need to be administered with more than one sets of simultaneous SQ infusions based on the maximum number of simultaneous infusions per site:*

_____ ml to be infused simultaneously into _____ subcutaneous site(s) and _____ ml to be infused simultaneously into _____ subcutaneous site(s)

☐ *Others*_____ *Qty:* _____*Refill:*_____

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:* _____

Physician

MD:	License:	DEA #:	NPI #:
Specialty:	Practice:	Email:	Hospital/Clinic:
Phys. Phone:	Phys. Fax:	Address:	Office Contact:

Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Physician; ☐ Other_____ *All the supplies including syringes and needles will be dispensed if requested.*

Physician Signature: _____ ☐ DAW (Dispense as Written) Date:_____

By signing below, I authorize Streamline DBA Decillion Healthcare ("Streamline DBA Decillion Healthcare") to: Collect my health condition and prescription information from my doctor, healthcare provider, health insurer or pharmacist in order to ensure its accuracy and completeness and to communicate to the patient support program of the pharmaceutical manufacturer (the "Program"); and contact my insurer, other potential funding sources, social workers, patient advocacy organizations, and patient assistance programs on my behalf to determine if I am eligible for assistance. I hereby authorize my doctor, healthcare provider, health insurer or pharmacist to provide my health condition and prescription information to Streamline DBA Decillion Healthcare and to the Program. I understand that I may revoke this authorization at anytime by sending a letter to Streamline DBA Decillion Healthcare.

Patient Signature:_____ Date:_____

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DECILLION HEALTHCARE

Demographics

Instructions for SQIg Administration for Nurse

Patient Name: _____ Date of Birth: _____

- 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 15minutes for 1st hour, then every 30 min for remainder of infusion
- Assure that pt is not volume depleted prior to initiation of SQIg infusion.

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 _____ gram x 10 = _____ ml

Infusion volume per site: If weight more than 40 kg: 30 ml/site; If weight less than 40 kg: 20 ml/site

Maximum number of simultaneous sites: 8 infusion sites, at least 2 inches apart

Gamunex-C 10%

Conversions: Gamunex-C dose _____ gram 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 _____ gram 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)

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 more than 40 kg: 20 ml/hr/site

If weight 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& 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.

Symptoms

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

Education

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

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.