NuFACTOR Specialty Pharmacy

SCIg Orders
(Subcutaneous immune globulin - autoimmune)

Fax all pages of this referral to our secure fax at (855) 270-7347.

Patient Information

Date:	Requested Start of Care Date:	State of pt's residence:
Patient name:		Date of birth:
Height:	Weight: lb / kg	
Primary Diagnosis:		ICD-10:
Secondary Diagnosis:		ICD-10:
Allergies:		

Subcutaneous Immune Globulin Orders

For options 1/2/3, pharmacy to select brand unless ordered to dispense brand as written: _____

Option 1: Dose & Directions:

Option 2: SCIG _____ **gm** **OR** _____ **gm / kg**

- ◯ once/week
- ◯ once/week but divide further in up to 5 doses based on patient tolerance/request
- ◯ other:

Option 3: Current or recommended *monthly* IV dose: _____ **gm** **OR** _____ **gm / kg**, then divide by four and administer:

- ◯ once/week
- ◯ once/week but divide further in up to 5 doses based on patient tolerance/request
- ◯ other:

Option 4: Hizentra brand. Per package insert for CIDP: ◯ **0.2 gm / kg** ◯ **0.4 gm / kg**

- Initiate Hizentra 1 week after the last IVIG infusion [NuFACTOR goal once insurance authorization and nursing/patient availability confirmed.]
- Recommended SC dose is 0.2 g/kg per week.
  - In the clinical study after transitioning from IVIG to Hizentra, a dose of 0.4 g/kg/week was also safe and effective to prevent CIDP relapse.
- If CIDP symptoms worsen, consider re-initiating treatment with an IVIG approved for the treatment of CIDP, while discontinuing Hizentra.
  - If improvement & stabilization observed during IVIG treatment, consider reinitiating Hizentra at 0.4 g/kg/week, while discontinuing IVIG.
  - If CIDP symptoms worsen on 0.4 g/kg/week, consider re-initiating therapy with IVIG, while discontinuing Hizentra.
- Monitor patient's clinical response and adjust duration of therapy based on patient need.

- ◯ once/week
- ◯ once/week but divide further in up to 5 doses based on patient tolerance/request
- ◯ other:

- Pharmacy to determine the # of sites unless alternate number of sites indicated here: _____
- For Medicare B: syringes, ☐ 60ml LL ☐ 30ml ☐ 20ml (K0552): # ___ /month

- Refill _____ months (Unless noted, prescriptions valid 1 year from date signed.)
- Dispense size(s) and quantity sufficient

May round Hizentra dose to nearest single-use vial size(s) and others to nearest vials size (weight ≤40 lbs) or 5gm vial size (adults) if exact vial size dose not ordered. Hizentra is manufactured as 200 mg/ml solution in sizes of 1 gm/5 ml, 2 gm/10 ml, 4 gm/20 ml and 10 gm/50 ml. Gammagard Liquid, Gammaked and Gamunex-C are manufactured as 100 mg/ml solution in sizes of 1 gm/10 ml, 2.5 gm/25 ml (except Gammaked), 5 gm/50 ml, 10 gm/100 ml and 20 gm/200 ml (and 30 gm/300 ml for Gammagard Liquid only).

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Patient Name:	State of pt's residence:

Premedication Orders / Other Orders

Patient Type	Drug	Description / Dispense Quantity Sufficient	Dose	Route / Frequency	Decline
Adult & Pediatric ≥12 years (if not at least 95 lb., follow <12 years dosing)	Acetaminophen	325 mg tab or 160 mg/5 ml oral 120 ml	325 - 650 mg	Orally pre-lg prn. May repeat q 4 - 6 hr prn. Max 3 gm/day.	Decline ☐
Pediatric 0 - 11 years		160 mg/5 ml oral 120 ml	10 mg/kg (round to nearest 1/4 tsp)	Orally pre-lg prn. May repeat q 4 - 6 hr prn. Max 50 mg/kg/day.	
Adult	Diphenhydramine	25 mg tab or 12.5 mg/5 ml oral 120 ml	25 - 50 mg	Orally pre-lg prn. May repeat q 4 - 6 hr prn.	Decline ☐
Pediatric ≥ 12 years			25 mg		
Pediatric 6 - 11 years		12.5 mg/5 ml oral 120 ml	12.5 - 25 mg		
Pediatric 2 - 5 years		12.5 mg/5 ml oral 120 ml	6.25 mg		
Adult & Pediatric ≥6 years	Loratadine (if excessive drowsiness from diphenhydramine)	10 mg tab or 5 mg/5 ml oral 120 ml	10 mg	Orally pre-lg prn. No repeat.	Decline ☐
Pediatric 2 – 5 years		5 mg/5 ml oral 120 ml	5 mg		
All	Lidocaine/prilocaine 2.5%/2.5% cream	30 gm tube (or other available size)	Apply topically 60" prior to subcutaneous needle placement and cover with occlusive dressing prn.		Decline ☐

OTHER ORDERS	

Anaphylaxis Orders

Patient Type	Drug	Description / Dispense Quantity Sufficient	*Reaction Severity	Dose	Route/Frequency
Adult	Diphenhydramine	25 mg tab #24 or 12.5 mg/5 ml oral 120 ml	Mild or Severe	50 mg	Orally every 6 hr.
Pediatric		12.5 mg/5 ml oral 120 ml		1.25 mg/kg (max 50 mg)	
Adult & Pediatric >66 lbs	Epinephrine	0.3 mg Auto-Injector #2	Severe	0.3 mg	IM x 1 dose. May repeat in 5 – 15 minutes as needed.
Pediatric 33 - 66 lbs		0.15 mg Auto-Injector #2		0.15 mg	
Pediatric <33 lbs		1 mg/ml 1 ml vial/amp #2		0.01 mg/kg	SC x 1 dose. May repeat in 5 – 15 minutes as needed.

*Mild allergic reactions include itching, hives, rash, nausea and/or vomiting
*Severe anaphylaxis reactions include angioedema, wheezing, difficulty breathing, swelling of eyelids or lips

Other Orders:	

Ancillary Supplies and DME Orders (Dispense quantity sufficient)

Ancillary supplies for the infusion of SCIG via Freedom 60/Edge infusion pump. For Medicare B: Supplies for maintenance of drug infusion catheter, per week (A4221).

Nursing Orders

Skilled Nursing Visits for education and teaching of SCIG side effects / management and administration by Freedom 60/Edge pump.

Nurse to administer SCIG per physician orders.

Lab Orders (cannot be drawn stat)

Test BUN/Scr as per payer requirement (usually every 6 – 12 months)

Physician Information

Signature:	Name:
	NPI#:
	Phone:
Date:	Fax:

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For any questions, please contact NuFACTOR Specialty Pharmacy at (800) 323-6832.