nufactor.
A SPECIALTY INFUSION COMPANY

For questions, call 1.800.323.6832

Subcutaneous Immune Globulin (SCIG) Orders

Fax all pages to (855) 270-7347

Patient Information

Order Date:	Requested Start of Care Date:	Date of Birth:	
Patient name:	Height:	Weight: lb / kg	
Address:	City:	State:	Zip:
Primary Diagnosis:		ICD-10:	
Secondary Diagnosis:		ICD-10:	
Allergies:			

SCIG Orders

IMMUNE DEFICIENCY DOSING

DOSE OPTIONS

1 _____ **gm** *OR* _____ **gm / kg**

2 *Monthly* IV dose: _____ **gm** *OR* _____ **gm / kg**

Select IV:SC conversion ratio (monthly dose will be divided by frequency ordered below):

- ◯ **1:1.37 (**Gammagard, Gammaked, Gamunex, Hizentra, Xembify inserts)
- ◯ **1:1.3** (Cutaquig and Cuvitru inserts)
- ◯ **1:1** (no conversion factor)

AUTOIMMUNE / OTHER DOSING

DOSE OPTIONS

1 _____ **gm** *OR* _____ **gm / kg**

2 *Monthly* IV dose: _____ **gm** *OR* _____ **gm / kg**

(monthly dose will be divided by frequency ordered below):

- Brand: _____ (pharmacy to select brand and/or concentration unless otherwise specified)
- Administer the above dose:
  ◯ once/week ◯ once/week but divide further in up to 5 doses based on patient tolerance/request ◯ ___ time(s) per ____ wk(s)
- Round dose to nearest available vial or per payer requirement. Decline ☐
- Pharmacist to adjust dose ordered in gm/kg if weight changes +/- 10% Decline ☐
- Pharmacy/nurse to determine the # of sites unless number of sites indicated here: _____
- Volume & rate/site per Nufactor guidelines as tolerated unless ordered otherwise.

- Syringes: 50 ml LL (if Freedom60), 20 ml or 30 ml (if FreedomEdge) [K0552]: # ___ /month
- Refill _____ months (Unless noted, prescriptions valid 1 year from date signed.) • Dispense size(s) and quantity sufficient

Cuvitru/Hizentra/Xembify (20%):1 gm/5 ml, 2 gm/10 ml, 4 gm/20 ml, 8 gm/40 ml (Cuvitru only), 10 gm/50 ml. Gammagard Liquid/Gammaked/Gamunex-C (10%): 1 gm/10 ml (not Gammaked), 2.5 gm/25 ml (not Gammaked), 5 gm/50 ml, 10 gm/100 ml and 20 gm/200 ml. Cutaquig (16.5%): 1 gm/6 ml, 1.65 gm/10 ml, 2 gm/12 ml, 3.3 gm/20 ml, 4 gm/24 ml and 8 gm/48 ml.

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-Ig 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-Ig 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-Ig 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-Ig 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

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Patient Name:

Anaphylaxis Orders (includes drugs/orders if loading IV dose ordered)

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 (auto-injector) or SC (vial/amp) 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.
Adult and Pediatric	Sodium chloride 0.9%	250 ml IV Bag #1	Severe (IV only)	250 ml	Stop causative drug, then administer IV at KVO rate.

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

Other Orders:

If IVIG Dose Needed Before SCIG (Immune Deficiency)

IVIG _____ **gm** *OR* _____ **gm / kg** once **daily** for ___ day(s) x 1 dose / course appx. 1 week before SCIG

- Pharmacy to select brand and/or concentration unless ordered to dispense brand as written: _____
- Round dose to nearest 5 gm vial or per payer requirement; nearest available vial size if weight <40 lbs. Decline ☐
- Titrate per Nufactor guidelines as tolerated unless ordered otherwise
- Dispense size(s) and quantity sufficient

Patient Type	Drug	Description	Dose	Route / Frequency	
Adult/Pedi > 15 kg	Sodium Chloride 0.9%	10 ml syringe	1 - 3 ml	pre/post use	If IV dose
	Heparin	10 units/ml 5 ml syringe	1 - 3 ml	post last NS	
Pedi ≤ 15 kg	Sodium Chloride 0.9%	10 ml syringe	1 - 3 ml	pre/post use	
	Heparin	10 units/ml 5 ml syringe	1 ml	post last NS	

Ancillary Supplies and DME Orders (Dispense quantity sufficient)

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

Nursing Orders (not applicable if independent with therapy)

- Skilled Nursing Visits for education and teaching of SCIG side effects / management and administration by Freedom 60/Edge pump.
- Nurse to administer IG and ancillary medications per physician orders.
- If IVIG loading dose: Nurse to obtain IV access via placement of peripheral IV or insertion of port needle when applicable. If IV access is not obtained after 3 attempts, nurse should contact Nufactor for assistance.

Other

Physician Information

Signature:

Date:

Name:

NPI#:

Address:

Phone: Fax:

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