SCIG Referral Form

REQUIRED INFORMATION

☐ This signed order form from the provider
☐ Patient demographics and insurance information
☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis (ICD-10 below)
☐ Documentation of any tried and failed therapies

Patient Name:	**DOB:**	**Weight:**
Allergies:	**Patient Phone:**	
Diagnosis and ICD-10:		

☐ **Pharmacist to identify clinically appropriate brand/infusion rates. May substitute based on product availability.**

☐ **Do not substitute. Administer brand**: _____

Dose: ☐ 100 mg/kg subcutaneous IG to be administered via syringe pump

☐ 150 mg/kg

☐ 200 mg/kg

☐ 400 mg/kg

☐ _____ mg/kg

Frequency: ☐ weekly ☐ every 2 weeks ☐ every ____ weeks ☐ one time **Refill**: ☐ PRN x 1 year OR _____ times dose

☐ **Adjust dose or frequency to maintain IgG concentration >500 to 700 mg/dL and/or based on response to therapy.**
*Consistent IgG trough concentrations are typically achieved after 3 to 6 months of regular therapy.

Protocol Pre-Medication Orders:

☐ Acetaminophen 650 mg PO OR ☐ Acetaminophen 1000 mg PO

☐ Diphenhydramine 25 mg PO OR ☐ Cetirizine 10 mg PO

Additional Pre-Medication Orders:

☐ EMLA Cream (Lidocaine 2.5% / Prilocaine 2.5 %) 30 g to use topically on injection site prior to needle insertion

☐ Other: _____

Supply Orders: ☐ Pharmacy to provide all supplies needed to complete therapy as prescribed

Nursing Orders: ☐ Pharmacy to provide nursing services for initial administration and teaching and as needed

☐ May use Burnham's Vital Care anaphylaxis protocol as needed

Additional Instructions/Labs:

Practitioner Name:	**Practitioner Signature:**	**Date:**
Practitioner Address:		