

# SCIG REFERRAL FORM

## PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

## REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Dems
- Most Recent Labs
- Medication List
- Current IG Levels

## PRIMARY DIAGNOSIS

- D80.0 Hereditary hypogammaglobulinemia
- D80.9 Immunodeficiency with predominantly antibody defects, unspecified
- D83.9 Common variable immunodeficiency, unspecified
- Other: \_\_\_\_\_

## LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: \_\_\_\_\_

## PRE-MEDICATIONS

- Per infusion clinic protocol: No recommended standard pre-meds for SCIG
- Provider Prescribed: \_\_\_\_\_

## PRIMARY MEDICATION ORDER

<b>Immune Globulin (subcutaneous)</b>	<b>Dosing</b>
<input type="checkbox"/> Cutaquig 16.5%	<input type="checkbox"/> _____ GRAMS SubQ once weekly
<input type="checkbox"/> Cuvitru 20%	<input type="checkbox"/> _____ milligrams SubQ once weekly
<input type="checkbox"/> Hyqvia 10%	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Xembify 20%	

For Hyqvia: Pharmacy to calculate ramp-up dose per the ramp-up schedule in the Full Prescribing Information  
First Dose:  Y  N  Refill x12 months unless otherwise noted: \_\_\_\_\_

## ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol  
(See flexcareinfusion.com for detailed policy)
- Other: Please fax other reaction orders if checking this box

## PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_