RELIANT SPECIALTY INFUSION

Immunology IVIG & Sub-Q **Fax: 833-808-0833**

Patient Information

Patient Name: _____ DOB: _____ Height: _____ Patient Contact #: _____

Medical Assessment: Diagnosis (ICD-10):

- ☐ Common Variable Immune Deficiency (D83.9)
- ☐ Common Immunity Deficiency & SCID (D80.4)
- ☐ Congenital Hypogammaglobulinemia (D80.0)
- ☐ Hypogammaglobulinemia (D80.1)
- ☐ Immunodeficiency with Increased IgM (D80.5)
- ☐ Immunodeficiency with Predominant T-Cell Defect (D83.1)
- ☐ Selective IgA Immunodeficiency (D80.2)
- ☐ Selective IgM Immunodeficiency (D80.4)
- ☐ Other Selective Immunodeficiency (D80.3)
- ☐ Wiscott – Aldrich Syndrome (D82.0)
- ☐ Other: _____

Allergies: _____

Pre-Medication Orders:

- ❑ APAP □ 325mg □ 500mg □ 650mg - PO 30 minutes before infusion.
- ❑ Diphenhydramine □ 25mg □ 50mg – PO 30 minutes before infusion OR □ 25mg IVP □ 50mg IVP
- ❑ Alternate Oral Antihistamines: □ Cetirizine 10mg □ Loratadine 10mg □ Fexofenadine 60mg or □180mg
- ❑ Methylprednisolone □ 40mg IVP □ 125mg IVP or other _____ mg IVP
- ❑ Famotidine □ 20mg PO □ 40mg PO □ 20mg IVP □ 40mg IVP
- ❑ Ondansetron □ 4 mg IVP □ 4 mg PO

Labwork: _____To by Drawn by: □ Infusion Clinic □ Referring Provider

Medication:

Patient's Current Weight: _____ lbs / kg (circle one)

IVIG: ☐ AIC to Determine (or) ☐ Brand: _____

□ Loading Dosage: Infuse _____ grams /kg over _____ days
□ Maintenance Dosage: Infuse _____ grams/kg every _____ weeks **Refills: _____**
□ Other Regimen: _____

Cutaquig

□ Infuse _____ grams every week. **Refills: _____**
□ Other Regimen: _____

Hizentra

□ Infuse _____ grams every week. **Refills: _____**
□ Other Regimen: _____

Hyqvia

□ Induction: Infuse _____ total grams SQ per induction protocol.

***** Administration of Induction Dosage in AIC / HCP office only*****

(Choose one)		□ Frequency – Every 4 Weeks	□ Frequency – Every 3 Weeks
1st Infusion	Week 1	Grams x 0.25	Grams x 0.33
2nd Infusion	Week 2	Grams x 0.5	Grams x 0.67
3rd Infusion	Week 4	Grams x 0.75	Administer Total grams
4th Infusion	Week 7	Administer Total Grams	N/A

□ Maintenance: Infuse _____ total grams every _____ weeks. **Refills: _____**

**** Maintenance Hyqvia Dosage to Infuse: □ in AIC / HCP Office □ Home Infusion Provider (transfer) ****

Physician Prescription Orders Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____Physician Name: _____

NPI #_____Physician Signature: _____Date: _____