Subcutaneous Immunoglobulin (SCIG)

IVX HEALTH

Provider Order Form rev. 3/11/25

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 05.01.2023)

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

IVX will select the product based on payor requirements, product availability, and indication: Cutaquig, Hizentra, HyQvia

SPECIAL INSTRUCTIONS

NAÏVE OR CONTINUING SCIG

Indicate the patient's experience with subcutaneous immunoglobulin (SCIG) therapy:

☐ Naïve to IG therapy / ☐ Continuing SCIG therapy
- Infuse _____grams OR _____ g/kg subcutaneously
- Frequency: ☐ once weekly / ☐ every 2 weeks / ☐ other: _____

(IVX Health Pharmacist will calculate the ramp up schedule per manufacturer's guidelines, if applicable.)

IVIG TO SCIG CONVERSION ORDER

Complete this section for patients transitioning from IVIG to SCIG therapy.

Prescriber to provide preferred subcutaneous dose and frequency:

- Infuse _____grams OR _____ g/kg subcutaneously
- Frequency: ☐ once weekly / ☐ every 2 weeks / ☐ other: _____

☐ Check here to allow IVX Health's pharmacist to calculate the equivalent subcutaneous dose.
- Please indicate previous IV dose and frequency: _____
- Please indicate desired SCIG frequency:_____

(IVX Health Pharmacist will calculate the equivalent subcutaneous dose, frequency, and ramp up schedule per manufacturer's guidelines, if applicable.)

☑ Administration rate: IVX Health will establish the administration rate based on therapy prescribing information.
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

Provider Name (Print) **Provider Signature** **Date**

FAX NUMBERS

☐ ARKANSAS: 501-451-5644	☐ COLUMBUS: 844-627-2675	☐ HARRISBURG: 844-859-4235	☐ MIAMI: 786-744-5687	☐ PIEDMONT TRIAD: 336-790-2200
☐ AUSTIN: 512-772-2824	☐ CONNECTICUT: 860-955-1532	☐ HOUSTON: 832-631-9595	☐ MIDDLE/WEST TN: 888-615-1445	☐ RALEIGH: 919-287-2551
☐ BAY AREA: 844-889-0275	☐ DALLAS: 469-947-6114	☐ INDIANAPOLIS: 844-983-2028	☐ NORTH CENTRAL FL: 352-756-4191	☐ SAN ANTONIO: 726-238-9950
☐ CHARLOTTE: 336-663-0143	☐ DAYTONA: 386-259-6096	☐ JACKSONVILLE: 904-212-2338	☐ NORTH JERSEY: 551-227-2823	☐ SARASOTA: 941-870-6550
☐ CHICAGO: 312-253-7244	☐ DELAWARE: 302-596-8553	☐ KANSAS CITY: 844-900-1292	☐ ORLANDO: 844-946-0867	☐ SOUTH JERSEY: 856-519-5309
☐ CINCINNATI: 844-946-0868	☐ EAST TN/TRI-CITIES: 615-425-7427	☐ LAKELAND: 863-316-3910	☐ PALM BEACH: 561-768-9044	☐ SOUTHWEST FL: 813-283-9144
	☐ FT. LAUDERDALE: 754-946-2052	☐ MELBOURNE: 321-800-9515	☐ PHILADELPHIA: 844-820-9641	☐ TAMPA: 844-946-0849