Site of Care

☐ Home Infusion
☐ Infusion Center
☐ Doctor's Office

Fax Referral to (855) 644-3687 or Email: Referrals@sandshealth.com

SubQ Immune Globulin Order Form

Sands Health will select the product based on product availability, indication and insurance requirement

Cutaquig 16.5% Hizentra 20% Xembify 20%

☐ DO NOT SUBSTITUTE. Administer brand:_____

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Mobile Number: _____

Patient Weight: _____ Patient Height: _____ Allergies: _____

Other Medications: _____

DIAGNOSIS (Provider must specify)

☐ Chronic Inflammatory Demyelinating Polyneuropathy, ICD10: _____
☐ Primary Immunodeficiency, ICD10: _____
☐ Myasthenia Gravis, ICD10: _____
☐ Other: _____

Prior to treatment – ensure the following information is complete and attached with referral:

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Benadryl 25mg PO ☐ Methylprednisolone (Solu-Medrol) ____ mg IVP

☐ Other: _____ Dose: _____ Route: _____

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MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
SCIG	☐ _____ Grams/Kg ☐ _____ Grams *Dose will be rounded up to nearest vial size.	Sub Q Infusion ☐ Administer as single day infusion ☐ Divide dose over ____ days	☐ Once ☐ Every _____ weeks ☐ Every_____ months

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

LABS/SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

PROVIDER INFORMATION

Provider Name: _____ Provider NPI: _____ Contact:_____

Phone: _____ Fax: _____ Email Address:_____

Signature: _____ Date: _____