

Subcutaneous Immune Globulin (SCIG) Home Infusion Request form

Complete and submit to local Transfusion Medicine Laboratory (TML)

Patient Name: _____
 Date of Birth(Y/M/D): _____
 Hospital #: _____
 Health Card Number: _____

Weight: _____ kg Height: _____ cm [IG Dose Calculator \(transfusionontario.org\)](http://transfusionontario.org)

Product Prescribed (please check): Cuvitru® Hizentra® HyQvia® Other _____

Currently receiving: IVIG SCIG New Patient Date of last IG infusion: _____

Serum IgG: _____ g/L Date: _____ (Mandatory if currently receiving IG for PID/SID; Result must be within 3-6 months of order)

Initial Request for SCIG or brand change (complete ALL information in box below)

Is this patient being referred to a program for training and support? If yes, please indicate the program. OnePath CSL Plus ONIT
 Other: _____

Indication for IG Request
[Utilization Management Guidelines – Transfusion Ontario](#)

****Request is valid for 12 months if patient currently on IG treatment. New patients with 'Other' indication, request is valid for 6 months.****

Primary Immune Deficiency (PID)
 Secondary Immune Deficiency (SID)
 (cause of SID: _____)
 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
 Other: _____

Prescribed dose of SCIG per month

0.2 g/kg
 0.3 g/kg
 0.4 g/kg
 0.5 g/kg
 0.6 g/kg
 1.0 g/kg
 Other: _____ g/kg

Administration Frequency:
 Administer: _____ g, over _____ days, every _____ week, for a total monthly dose of _____ g
 Round dose to nearest gram/vial size.

For HyQvia® ONLY:
 HyQvia® ramp up dose provided over 4–7-weeks differs from regular dosing schedule noted above, therefore, please specify ramp up patient dose per week in shaded box below (vial sizes available for the ramp up are 2.5, 5, 10, 20, and 30 grams):

Infusion Number	Week	Percent of Target Dose	Standard ramp up for 30 grams q4weeks	Other ramp up dose Patient Dose (g)- please specify
1	1	25%	7.5 g	
2	2	50%	15 g	
3	4	75%	22.5 g	
4	7	100%	30 g	

Annual Renewal or Change SCIG dose (complete information below)

Annual Health Review regarding IG treatment (comments / response to therapy / infections or antibiotic use in past 12 months): _____

Continue current SCIG dose

Per month dose: _____ g/kg Total monthly dose: _____ g
 Administer: _____ g, over _____ days, every _____ week(s)

Change SCIG dose

Per month dose: _____ g/kg Total monthly dose: _____ g
 Administer: _____ g, over _____ days, every _____ week(s)
 Reason: _____

Prescriber Name (print): _____ Prescriber phone/ext.: _____
 Prescriber Signature: _____ Date: _____