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SMH/JPOCSC Pre-Printed Orders and
Patient Enrolment Notification for

Subcutaneous Immune Globulin (SCIG)
Home Infusion Program

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DRUG & FOOD ALLERGIES

• **Mandatory** ☐ **Optional: Prescriber check (✓) to initiate, cross out and initial any orders not indicated.**

Physician's Order for Subcutaneous Immune Globulin (SCIG)

Date: _____ ☐ Informed consent completed Patient's Diagnosis: _____

SCIG brand name: _____

Concentration ☐ 20% = 0.2 g/mL ☐ 16.5% = 0.165 g/mL ☐ Other _____

☐ Option #1: Converting Intravenous Immune Globulin (IVIG) dose to SCIG dose

IVIG dosage (grams) _____ ÷ previous treatment interval (weeks) _____ = _____ IVIG dose grams/week

IVIG dose _____ grams/week ÷ _____ grams/mL (g/mL) = _____ mL/week **SCIG**

☐ Option #2: Ordering SCIG usual adult dosage is 0.1 g/kg/week.

Patient's weight _____ kg x dosage 0.1 g/kg/week = _____ g/week **SCIG**

SCIG dosage _____ g/week ÷ _____ g/mL = _____ mL/week **SCIG**

☐ Option #3: Weekly SCIG _____ mL/week **SCIG**

Date (dd/mm/yyyy):	**Time:**	**Prescriber Signature:**	**Printed Name and College ID:**

SCIG Home Infusion Program Notification for Transfusion Medicine Service (TMS)

Hospital/TMS name: _____ TMS/Lab telephone: _____

This is the first notification for this patient: ☐ Yes ☐ No TMS/Lab fax: _____

This is an order change: ☐ Yes ☐ No Product will be required: ☐ every month ☐ every 3 months

Product required: _____ x 5 mL vials _____ x 10 mL vials _____ x 20 mL vials _____ x_____ mL vials

_____ x 40 mL vials _____ x 50 mL vials _____ x_____ mL vials _____ x_____ mL vials

Clinic RN Signature: _____ Order expired on (date): _____

SCIG Clinic will fax TMS/Lab notification of product pickup approximately two weeks before the required date.

SCIG Clinic contact: 604-363-7373 Fax: 604-582-3742

TMS Use only

Reviewed by: _____ Notes: _____

☐ Patient's TMS computer/record updated Order expire date: _____

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Subcutaneous Immune Globulin (SCIG)

Home Infusion Program

1. The patient must have a confirmed diagnosis for an approved indication for SCIG. Requests for SCIG for non-approved/licensed indications will require approval by a transfusion medicine physician.
   - Approved indications: Primary Immune Deficiency, Secondary Immune Deficiency as outlined below

2. Patients referred with hypogammaglobulinernia must have a confirmed diagnosis (reduced total IgG or IgG subclasses and/or inadequate response to immunization) with recurrent bacterial infection.

   Although any hypogammaglobulinernic patient who requires IgG replacement may be a candidate for subcutaneous home infusion, this method may be particularly appealing or useful for patients who:
   - experience adverse events during or immediately after intravenous immune globulin (IVIG) infusion:
   - have peripheral venous access problems;
   - desire greater convenience and/or independence from hospital IV administration.

3. The patient or caregiver who will be infusing the patient must be capable of being trained to administer SCIG safely and accurately in the home setting.

   When considering which patients will be good candidates, attention should be given to a patient's/caregiver's:
   - ability to read and follow instructions;
   - ability to learn;
   - self-motivation;
   - probable compliance;
   - physical limitations (especially for manual dexterity).

4. The patient or caregiver must be trained to administer SCIG, as outlined below. This training must include a minimum of three sessions of supervised SCIG self-injections.

5. The patient (or guardian) must be made aware that SCIG is a blood product with associated risks, that infusion in the home is associated with additional risk, and must provide written informed consent to SCIG home infusion

6. The patient (or guardian) must agree in writing to complete and submit infusion logs.

7. The patient's home infusion setting must have a working telephone and should have access to rapidly available emergency assistance. A physician must be available by telephone for immediate consultations should urgent medical care be required.

8. For patients under age 19, and for all patients during their first month of SCIG therapy, a competent adult must be available in the home infusion setting to assist the patient for the entire period of the infusion and must remain available to the patient for at least 60 minutes thereafter. For patients aged 19 and older, the requirement for another competent adult to be in attendance during the procedure and for at least 60 minutes thereafter should be reviewed following the first month of SCIG home infusion. If, after the first month, the patient has experienced no serious adverse events, it may be sufficient to have another competent adult available via telephone. Program staff must emphasize the product risks and work with the patient/caregiver to develop a plan for whom, how and under what circumstances the patient/caregiver would contact another competent adult, the SCIG Clinic nurse, ordering physician, general practitioner, or emergency services based on an algorithm of escalating risk.

9. The patient's general practitioner, emergency department staff and/or community health nurse (in rural communities) must be informed both before and after the training period, so that they are aware there is a SCIG home infusion patient in their community and can ensure that appropriate services are readily available in the event the patient has a problem.

Contraindications:

1. SCIG is contraindicated in individuals with a history of anaphylactic or severe systemic response to immune globulin preparations, and in persons with selective immunoglobulin A (IgA) deficiency (serum Ig < 0.05 g/L) who have known antibody against IgA.

2. Caution should be used in patients with platelet disorders or other bleeding tendencies.

3. The safety and efficacy of SCIG has not been studied in patients < 2 years old.