Cuvitru Order Form
(Immune Globulin SubQ Injection)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F Ht: _____ Wt: _____ lbs / kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code (PROVIDE COMPLETE CODE)

☐ D80._____ Hypogammaglobulinemia
☐ D81._____ Combined Immunodeficiency
☐ D82.0 Wiskott-Aldrich Syndrome
☐ D83._____ Common Variable Immune Deficiency
Other: _____

Prescribing Information

For patients previously on another IG treatment, it is recommended to administer the first dose approximately one week after the last infusion of their previous treatment.

If applicable:

- Previous IG Therapy: Date of Last Dose:

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
LAB RESULTS: **IG Levels**

PRESCRIPTION

Cuvitru (Immune Globulin 10% SubQ Injection)

Subcutaneous administration to infuse _____ total grams every _____ week(s) for one year

INFUSION VOLUME & RATE				
Patients	First Two Infusions		Subsequent Infusions	
	< 40 kg	≥ 40 kg	< 40 kg	≥ 40 kg
Volume (mL/site)	≤ 20	≤ 60	≤ 60	
Rate (mL/hr/site)	10-20		≤ 60	

In the event of an adverse reaction, utilize Medix Infusion adverse reaction protocol.

Post Treatment Observations: The patient is observed for 30 minutes following the first infusion.

Comments: _____

_____

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ ***Signature:*** _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip:_____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____