octagam® 10%

Immune Globulin
Intravenous (Human) 10%
Liquid Preparation

octagam® 5%

Immune Globulin
Intravenous (Human) 5%
Liquid Preparation

MY IVIg THERAPY TRACKER

AN INFUSION JOURNAL FOR PATIENTS AND CAREGIVERS

IVIg=intravenous immunoglobulin.

Please see Full Prescribing Information, including complete BOXED WARNING, available here for OCTAGAM 10% or here for OCTAGAM 5%.

Pfizer

INDICATIONS AND USAGE FOR OCTAGAM 10%

OCTAGAM 10% is indicated for the treatment of chronic immune thrombocytopenic purpura (cITP) in adults and dermatomyositis (DM) in adults. For patients with cITP, it is used to rapidly increase the platelet count in the blood to help control or prevent bleeding. For patients with DM, it helps improve muscle function and skin rash.

OCTAGAM 10% is a liquid medication that contains Immunoglobulin G (IgG). OCTAGAM 10% is made from human plasma donated by healthy people. OCTAGAM 10% is given through the vein (intravenously) in a hospital, infusion center, or at home.

IMPORTANT SAFETY INFORMATION

- Do not use OCTAGAM 10% if you have had a severe allergic reaction to IgG or other blood products or have deficiencies of immunoglobulin A (IgA) with antibodies to IgA.
- OCTAGAM 10% can cause the following:
  - Blood clots in your heart, brain, lungs or other areas of your body
  - Kidney problems, or kidney failure
- Tell your healthcare provider (HCP) if you have an allergy to corn. OCTAGAM 10% contains a type of sugar that is made from corn.
- OCTAGAM 10% can cause the following serious side effects. Contact your HCP if you experience the following:
  - Swelling in your mouth or throat, hives/itching, breathing problems, wheezing, fainting, tightness in your chest, or dizziness. This could be a serious allergic reaction.
  - Decreased urination, swelling in your legs, sudden weight gain, or breathing problems, which could mean kidney failure
  - Pain and/or swelling of an arm or leg with warmth in the affected area, discoloration of an arm or leg, unexplained shortness of breath, chest pain or discomfort that worsens with deep breathing, unexplained rapid pulse, or numbness or weakness on one side of the body; these could be signs of a blood clot.
  - Yellow skin or eyes, dark-colored urine, fatigue, or increased heart rate, which could be signs of a blood problem.
  - Headache, stiff neck, drowsiness, fever, sensitivity to light, painful eye movements, or nausea and vomiting, which could mean an inflammation of the membranes covering your brain or spinal cord
  - Trouble breathing, chest pain, blue lips, arms or legs, and fever, which could be related to a lung problem. This typically occurs 1 to 6 hours following infusion.

Common side effects include headache, fever, nausea, vomiting, increased blood pressure, chills, musculoskeletal pain, dyspnea, infusion site reactions, and increased heart rate.

If you use a blood glucose monitor, check with your HCP to ensure that your monitor and test strips are acceptable to use while you are receiving OCTAGAM 10%.

These are not all of the possible side effects with OCTAGAM 10%. Tell your HCPs about any side effects that you have that cause concern or don't go away.

Please see Full Prescribing Information, including complete BOXED WARNING, available here for OCTAGAM 10% or here for OCTAGAM 5%.

INDICATION AND USAGE FOR OCTAGAM 5%

OCTAGAM® 5% [Immune Globulin Intravenous (Human)] liquid is indicated for the treatment of primary humoral immunodeficiency (PI).

OCTAGAM 5% is a liquid medication that contains Immunoglobulin G (IgG). OCTAGAM 5% is made from human blood plasma donated by healthy people. OCTAGAM 5% is given through the vein (intravenously) in a hospital, infusion center, or at home.

IMPORTANT SAFETY INFORMATION

- Do not use OCTAGAM 5% if you have had a severe allergic reaction to IgG or other blood products or have deficiencies of immunoglobulin A (IgA) with antibodies to IgA
- OCTAGAM 5% can cause the following:
  - Blood clots in your heart, brain, lungs, or other areas of your body
  - Kidney problems, or kidney failure
- Do not use OCTAGAM 5% if you are allergic to corn
  - Tell your healthcare provider (HCP) if you have an allergy to corn. OCTAGAM 5% contains a type of sugar that is made from corn
- OCTAGAM 5% can cause the following serious side effects. Contact your HCP if you experience the following:
  - Swelling in your mouth or throat, hives/itching, breathing problems, wheezing, fainting, tightness in your chest, or dizziness. This could be a serious allergic reaction
  - Decreased urination, swelling in your legs, sudden weight gain, or breathing problems, which could be signs of kidney failure
  - Pain and/or swelling of an arm or leg with warmth in the affected area, discoloration of an arm or leg, unexplained shortness of breath, chest pain or discomfort that worsens with deep breathing, unexplained rapid pulse, or numbness or weakness on one side of the body; these could be signs of a blood clot
  - Yellow skin or eyes, dark-colored urine, fatigue, or increased heart rate, which could be signs of a blood problem
  - Headache, stiff neck, drowsiness, fever, sensitivity to light, painful eye movements, or nausea and vomiting, which could mean an inflammation of the membranes covering your brain or spinal cord
  - Trouble breathing, chest pain, blue lips, arms or legs, and fever, which could be related to a lung problem. This typically occurs 1 to 6 hours following infusion

Common side effects include headache and nausea.

If you use a blood glucose monitor, check with your HCP to ensure that your type of monitor and test strips can be used while you are receiving OCTAGAM 5%.

These are not all of the possible side effects with OCTAGAM 5%. Tell your HCPs about any side effects that you have.

Please see Full Prescribing Information, including complete BOXED WARNING, available here for OCTAGAM 10% or here for OCTAGAM 5%.

Why do I need to record my treatment experience?

This IVIg therapy tracker has been given to you because you're beginning intravenous immunoglobulin (IVIg) therapy, either at home or in an infusion center.

A therapy tracker can help you document your IVIg therapy infusions. After each infusion, please take a few minutes to record your experience.

This record will allow you and your nurse, pharmacist, or doctor to see what is working well or to make any adjustments. It will also allow you and your doctor to follow your progress over time. By keeping a record of your infusion experiences, you will be playing an active role in your own treatment.

Starting on pages 6 and 7, there are two pages to complete for each of your infusions. Remember to write the date as well as the time you start and finish each infusion. Each page includes brief questions to help guide you in your note-taking, as well as a space to jot down any questions for your treatment team.

Consult your nurse, pharmacist, or doctor if you have any questions and to discuss any concerns you may have.

Ig Companion

Download the Pfizer Ig Companion app on your phone or tablet to digitally record your infusions. The mobile app is free and is designed to help support patients and caregivers with their treatment experience. ***See pages 30 and 31 for more information.***

octagam® 10%
Immune Globulin Intravenous (Human) 10% Liquid Preparation

octagam® 5%
Immune Globulin Intravenous (Human) 5% Liquid Preparation

My IVIg therapy tracker information

▲ NAME

▲ MEDICAL CONDITION REQUIRING IVIg THERAPY

LOCATION *(check one)* ▶ ☐ HOME ☐ INFUSION CENTER

▲ SPECIAL NOTES/ADDITIONAL INFORMATION

▼ LIST ALL MEDICATIONS YOU CURRENTLY TAKE (INCLUDING OVER-THE-COUNTER, VITAMINS, AND SUPPLEMENTS):

IN CASE OF EMERGENCY, DIAL 911

▲ EMERGENCY CONTACT	▲ PHONE	▲ EMAIL
▲ NURSE	▲ PHONE	▲ EMAIL
▲ DOCTOR	▲ PHONE	▲ EMAIL
▲ PHARMACY	▲ PHONE	▲ EMAIL

Please see Full Prescribing Information, including complete BOXED WARNING, available here for OCTAGAM 10% or here for OCTAGAM 5%.

octagam® 10%
Immune Globulin Intravenous (Human) 10% Liquid Preparation

octagam® 5%
Immune Globulin Intravenous (Human) 5% Liquid Preparation

My IVIg infusion details

▲ DATE *(month/day/year)*

▲ INFUSION NUMBER

▲ OCTAGAM 10% OR OCTAGAM 5% LOT NUMBER

LOCATION *(check one)* ▶ ☐ HOME ☐ INFUSION CENTER

▲ INFUSION START TIME *(am/pm)*

▲ INFUSION END TIME *(am/pm)*

▲ INFUSION DURATION *(hr/min)*

OVERALL EXPERIENCE *(check one)* ▶ ☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

MONITORING EXPERIENCE *(check one)* ▶ ☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

▲ WHAT WENT WELL

▲ WHAT DIDN'T GO WELL

▲ HOW DID YOU FEEL DURING AND AFTER THE INFUSION?

Did you remember to drink a lot of water?

DAY BEFORE AND DAY OF INFUSION *(check one)* ▶ ☐ YES ☐ NO

IF YES, HOW MANY 8 OZ GLASSES? *(check one)* ▶ ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

DURING THE INFUSION *(check one)* ▶ ☐ YES ☐ NO

IF YES, HOW MANY GLASSES? *(check one)* ▶ ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

Did you remember to avoid caffeine/alcohol the day before and day of the infusion?

CAFFEINE *(check one)* ▶ ☐ YES ☐ NO
(coffee, tea, energy drinks, energy pills, or soft drinks)

ALCOHOL *(check one)* ▶ ☐ YES ☐ NO

Please see Full Prescribing Information, including complete BOXED WARNING, available here for OCTAGAM 10% or here for OCTAGAM 5%.

octagam® 10%
Immune Globulin Intravenous (Human) 10% Liquid Preparation

octagam® 5%
Immune Globulin Intravenous (Human) 5% Liquid Preparation

My IVIg infusion details

Did you have any symptoms? *(check all that apply)*

☐ **HEADACHE**

SEVERITY *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **FEVER**

WHAT WAS YOUR TEMPERATURE?

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **INCREASED HEART RATE**

WHAT WAS YOUR HEART RATE?

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **NAUSEA**

SEVERITY *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **PAIN**

WHERE WAS IT LOCATED?

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **FLU-LIKE SYMPTOMS**

SEVERITY *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

DESCRIBE OTHER SYMPTOMS AND WHAT ACTIONS YOU TOOK

CONTACT YOUR HEALTHCARE PROVIDER IF YOU ARE CONCERNED ABOUT ANY SYMPTOMS

QUESTIONS FOR YOUR NURSE OR DOCTOR

NEXT INFUSION DATE

REVIEW YOUR TREATMENT EXPERIENCE WITH YOUR NURSE OR DOCTOR

Please see Full Prescribing Information, including complete BOXED WARNING, available here for OCTAGAM 10% or here for OCTAGAM 5%.

octagam® 10%
Immune Globulin Intravenous (Human) 10% Liquid Preparation

octagam® 5%
Immune Globulin Intravenous (Human) 5% Liquid Preparation

My IVIg infusion details

▲ DATE *(month/day/year)* ▲ INFUSION NUMBER

▲ OCTAGAM 10% OR OCTAGAM 5% LOT NUMBER LOCATION *(check one)* ▶ ☐ HOME ☐ INFUSION CENTER

▲ INFUSION START TIME *(am/pm)* ▲ INFUSION END TIME *(am/pm)* ▲ INFUSION DURATION *(hr/min)*

OVERALL EXPERIENCE *(check one)* ▶ ☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

MONITORING EXPERIENCE *(check one)* ▶ ☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

▲ WHAT WENT WELL

▲ WHAT DIDN'T GO WELL

▲ HOW DID YOU FEEL DURING AND AFTER THE INFUSION?

Did you remember to drink a lot of water?

DAY BEFORE AND DAY OF INFUSION *(check one)* ▶ ☐ YES ☐ NO

IF YES, HOW MANY 8 OZ GLASSES? *(check one)* ▶ ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

DURING THE INFUSION *(check one)* ▶ ☐ YES ☐ NO

IF YES, HOW MANY GLASSES? *(check one)* ▶ ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

Did you remember to avoid caffeine/alcohol the day before and day of the infusion?

CAFFEINE *(check one)* ▶ ☐ YES ☐ NO
(coffee, tea, energy drinks, energy pills, or soft drinks)

ALCOHOL *(check one)* ▶ ☐ YES ☐ NO

Please see Full Prescribing Information, including complete BOXED WARNING, available here for OCTAGAM 10% or here for OCTAGAM 5%.

octagam® 10%
Immune Globulin Intravenous (Human) 10% Liquid Preparation

octagam® 5%
Immune Globulin Intravenous (Human) 5% Liquid Preparation

My IVIg infusion details

Did you have any symptoms? *(check all that apply)*

☐ **HEADACHE**

▼ **SEVERITY** *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

▲ **WHEN DID IT START?**
(before/during/after infusion)

▲ **HOW LONG DID IT LAST?**
(approximate duration)

▲ **WHAT DID YOU DO ABOUT IT?**

☐ **FEVER**

▲ **WHAT WAS YOUR TEMPERATURE?**

▲ **WHEN DID IT START?**
(before/during/after infusion)

▲ **HOW LONG DID IT LAST?**
(approximate duration)

▲ **WHAT DID YOU DO ABOUT IT?**

☐ **INCREASED HEART RATE**

▲ **WHAT WAS YOUR HEART RATE?**

▲ **WHEN DID IT START?**
(before/during/after infusion)

▲ **HOW LONG DID IT LAST?**
(approximate duration)

▲ **WHAT DID YOU DO ABOUT IT?**

☐ **NAUSEA**

▼ **SEVERITY** *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

▲ **WHEN DID IT START?**
(before/during/after infusion)

▲ **HOW LONG DID IT LAST?**
(approximate duration)

▲ **WHAT DID YOU DO ABOUT IT?**

☐ **PAIN**

▲ **WHERE WAS IT LOCATED?**

▲ **WHEN DID IT START?**
(before/during/after infusion)

▲ **HOW LONG DID IT LAST?**
(approximate duration)

▲ **WHAT DID YOU DO ABOUT IT?**

☐ **FLU-LIKE SYMPTOMS**

▼ **SEVERITY** *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

▲ **WHEN DID IT START?**
(before/during/after infusion)

▲ **HOW LONG DID IT LAST?**
(approximate duration)

▲ **WHAT DID YOU DO ABOUT IT?**

▲ **DESCRIBE OTHER SYMPTOMS AND WHAT ACTIONS YOU TOOK**

CONTACT YOUR HEALTHCARE PROVIDER IF YOU ARE CONCERNED ABOUT ANY SYMPTOMS

▲ **QUESTIONS FOR YOUR NURSE OR DOCTOR**

▲ **NEXT INFUSION DATE**

REVIEW YOUR TREATMENT EXPERIENCE WITH YOUR NURSE OR DOCTOR

Please see Full Prescribing Information, including complete BOXED WARNING, available here for OCTAGAM 10% or here for OCTAGAM 5%.

octagam® 10%
Immune Globulin Intravenous (Human) 10% Liquid Preparation

octagam® 5%
Immune Globulin Intravenous (Human) 5% Liquid Preparation

My IVIg infusion details

▲ DATE *(month/day/year)* ▲ INFUSION NUMBER

▲ OCTAGAM 10% OR OCTAGAM 5% LOT NUMBER LOCATION *(check one)* ▶ ☐ HOME ☐ INFUSION CENTER

▲ INFUSION START TIME *(am/pm)* ▲ INFUSION END TIME *(am/pm)* ▲ INFUSION DURATION *(hr/min)*

OVERALL EXPERIENCE *(check one)* ▶ ☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

MONITORING EXPERIENCE *(check one)* ▶ ☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

▲ WHAT WENT WELL

▲ WHAT DIDN'T GO WELL

▲ HOW DID YOU FEEL DURING AND AFTER THE INFUSION?

Did you remember to drink a lot of water?

DAY BEFORE AND DAY OF INFUSION *(check one)* ▶ ☐ YES ☐ NO

IF YES, HOW MANY 8 OZ GLASSES? *(check one)* ▶ ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

DURING THE INFUSION *(check one)* ▶ ☐ YES ☐ NO

IF YES, HOW MANY GLASSES? *(check one)* ▶ ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

Did you remember to avoid caffeine/alcohol the day before and day of the infusion?

CAFFEINE *(check one)* ▶ ☐ YES ☐ NO
(coffee, tea, energy drinks, energy pills, or soft drinks)

ALCOHOL *(check one)* ▶ ☐ YES ☐ NO

Please see Full Prescribing Information, including complete BOXED WARNING, available here for OCTAGAM 10% or here for OCTAGAM 5%.

octagam® 10%
Immune Globulin Intravenous (Human) 10% Liquid Preparation

octagam® 5%
Immune Globulin Intravenous (Human) 5% Liquid Preparation

My IVIg infusion details

Did you have any symptoms? *(check all that apply)*

☐ HEADACHE
- SEVERITY *(check one)* (1=mild to 5=very severe)
  ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
- WHEN DID IT START? (before/during/after infusion)
- HOW LONG DID IT LAST? (approximate duration)
- WHAT DID YOU DO ABOUT IT?

☐ FEVER
- WHAT WAS YOUR TEMPERATURE?
- WHEN DID IT START? (before/during/after infusion)
- HOW LONG DID IT LAST? (approximate duration)
- WHAT DID YOU DO ABOUT IT?

☐ INCREASED HEART RATE
- WHAT WAS YOUR HEART RATE?
- WHEN DID IT START? (before/during/after infusion)
- HOW LONG DID IT LAST? (approximate duration)
- WHAT DID YOU DO ABOUT IT?

☐ NAUSEA
- SEVERITY *(check one)* (1=mild to 5=very severe)
  ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
- WHEN DID IT START? (before/during/after infusion)
- HOW LONG DID IT LAST? (approximate duration)
- WHAT DID YOU DO ABOUT IT?

☐ PAIN
- WHERE WAS IT LOCATED?
- WHEN DID IT START? (before/during/after infusion)
- HOW LONG DID IT LAST? (approximate duration)
- WHAT DID YOU DO ABOUT IT?

☐ FLU-LIKE SYMPTOMS
- SEVERITY *(check one)* (1=mild to 5=very severe)
  ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
- WHEN DID IT START? (before/during/after infusion)
- HOW LONG DID IT LAST? (approximate duration)
- WHAT DID YOU DO ABOUT IT?

- DESCRIBE OTHER SYMPTOMS AND WHAT ACTIONS YOU TOOK

CONTACT YOUR HEALTHCARE PROVIDER IF YOU ARE CONCERNED ABOUT ANY SYMPTOMS

- QUESTIONS FOR YOUR NURSE OR DOCTOR
- NEXT INFUSION DATE

REVIEW YOUR TREATMENT EXPERIENCE WITH YOUR NURSE OR DOCTOR

Please see Full Prescribing Information, including complete BOXED WARNING, available here for OCTAGAM 10% or here for OCTAGAM 5%.

octagam® 10%
Immune Globulin Intravenous (Human) 10% Liquid Preparation

octagam® 5%
Immune Globulin Intravenous (Human) 5% Liquid Preparation

My IVIg infusion details

▲ **DATE** *(month/day/year)* ▲ **INFUSION NUMBER**

▲ **OCTAGAM 10% OR OCTAGAM 5% LOT NUMBER** **LOCATION** *(check one)* ▶ ☐ **HOME** ☐ **INFUSION CENTER**

▲ **INFUSION START TIME** *(am/pm)* ▲ **INFUSION END TIME** *(am/pm)* ▲ **INFUSION DURATION** *(hr/min)*

OVERALL EXPERIENCE *(check one)* ▶ ☐ **EXCELLENT** ☐ **VERY GOOD** ☐ **GOOD** ☐ **FAIR** ☐ **POOR**

MONITORING EXPERIENCE *(check one)* ▶ ☐ **EXCELLENT** ☐ **VERY GOOD** ☐ **GOOD** ☐ **FAIR** ☐ **POOR**

▲ **WHAT WENT WELL**

▲ **WHAT DIDN'T GO WELL**

▲ **HOW DID YOU FEEL DURING AND AFTER THE INFUSION?**

Did you remember to drink a lot of water?

DAY BEFORE AND DAY OF INFUSION *(check one)* ▶ ☐ **YES** ☐ **NO**

IF YES, HOW MANY 8 OZ GLASSES? *(check one)* ▶ ☐ **1-2** ☐ **3-5** ☐ **6-8** ☐ **MORE**

DURING THE INFUSION *(check one)* ▶ ☐ **YES** ☐ **NO**

IF YES, HOW MANY GLASSES? *(check one)* ▶ ☐ **1-2** ☐ **3-5** ☐ **6-8** ☐ **MORE**

Did you remember to avoid caffeine/alcohol the day before and day of the infusion?

CAFFEINE *(check one)* ▶ ☐ **YES** ☐ **NO**
(coffee, tea, energy drinks, energy pills, or soft drinks)

ALCOHOL *(check one)* ▶ ☐ **YES** ☐ **NO**

Please see Full Prescribing Information, including complete BOXED WARNING, available here for OCTAGAM 10% or here for OCTAGAM 5%.

octagam® 10%
Immune Globulin Intravenous (Human) 10% Liquid Preparation

octagam® 5%
Immune Globulin Intravenous (Human) 5% Liquid Preparation

My IVIg infusion details

Did you have any symptoms? *(check all that apply)*

☐ **HEADACHE**

SEVERITY *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **FEVER**

WHAT WAS YOUR TEMPERATURE?

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **INCREASED HEART RATE**

WHAT WAS YOUR HEART RATE?

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **NAUSEA**

SEVERITY *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **PAIN**

WHERE WAS IT LOCATED?

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **FLU-LIKE SYMPTOMS**

SEVERITY *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

DESCRIBE OTHER SYMPTOMS AND WHAT ACTIONS YOU TOOK

CONTACT YOUR HEALTHCARE PROVIDER IF YOU ARE CONCERNED ABOUT ANY SYMPTOMS

QUESTIONS FOR YOUR NURSE OR DOCTOR

NEXT INFUSION DATE

REVIEW YOUR TREATMENT EXPERIENCE WITH YOUR NURSE OR DOCTOR

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octagam® 5%
Immune Globulin Intravenous (Human) 5% Liquid Preparation

My IVIg infusion details

▲ DATE *(month/day/year)* ▲ INFUSION NUMBER

▲ OCTAGAM 10% OR OCTAGAM 5% LOT NUMBER LOCATION *(check one)* ▶ ☐ HOME ☐ INFUSION CENTER

▲ INFUSION START TIME *(am/pm)* ▲ INFUSION END TIME *(am/pm)* ▲ INFUSION DURATION *(hr/min)*

OVERALL EXPERIENCE *(check one)* ▶ ☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

MONITORING EXPERIENCE *(check one)* ▶ ☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

▲ WHAT WENT WELL

▲ WHAT DIDN'T GO WELL

▲ HOW DID YOU FEEL DURING AND AFTER THE INFUSION?

Did you remember to drink a lot of water?

DAY BEFORE AND DAY OF INFUSION *(check one)* ▶ ☐ YES ☐ NO

IF YES, HOW MANY 8 OZ GLASSES? *(check one)* ▶ ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

DURING THE INFUSION *(check one)* ▶ ☐ YES ☐ NO

IF YES, HOW MANY GLASSES? *(check one)* ▶ ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

Did you remember to avoid caffeine/alcohol the day before and day of the infusion?

CAFFEINE *(check one)* ▶ ☐ YES ☐ NO
(coffee, tea, energy drinks, energy pills, or soft drinks)

ALCOHOL *(check one)* ▶ ☐ YES ☐ NO

Please see Full Prescribing Information, including complete BOXED WARNING, available here for OCTAGAM 10% or here for OCTAGAM 5%.

octagam® 10%
Immune Globulin Intravenous (Human) 10% Liquid Preparation

octagam® 5%
Immune Globulin Intravenous (Human) 5% Liquid Preparation

My IVIg infusion details

Did you have any symptoms? *(check all that apply)*

☐ **HEADACHE**

SEVERITY *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **FEVER**

WHAT WAS YOUR TEMPERATURE?

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **INCREASED HEART RATE**

WHAT WAS YOUR HEART RATE?

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **NAUSEA**

SEVERITY *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **PAIN**

WHERE WAS IT LOCATED?

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **FLU-LIKE SYMPTOMS**

SEVERITY *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

DESCRIBE OTHER SYMPTOMS AND WHAT ACTIONS YOU TOOK

CONTACT YOUR HEALTHCARE PROVIDER IF YOU ARE CONCERNED ABOUT ANY SYMPTOMS

QUESTIONS FOR YOUR NURSE OR DOCTOR

NEXT INFUSION DATE

REVIEW YOUR TREATMENT EXPERIENCE WITH YOUR NURSE OR DOCTOR

Please see Full Prescribing Information, including complete BOXED WARNING, available here for OCTAGAM 10% or here for OCTAGAM 5%.

octagam® 10%
Immune Globulin Intravenous (Human) 10% Liquid Preparation

octagam® 5%
Immune Globulin Intravenous (Human) 5% Liquid Preparation

My IVIg infusion details

▲ DATE *(month/day/year)* ▲ INFUSION NUMBER

▲ OCTAGAM 10% OR OCTAGAM 5% LOT NUMBER LOCATION *(check one)* ▶ ☐ HOME ☐ INFUSION CENTER

▲ INFUSION START TIME *(am/pm)* ▲ INFUSION END TIME *(am/pm)* ▲ INFUSION DURATION *(hr/min)*

OVERALL EXPERIENCE *(check one)* ▶ ☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

MONITORING EXPERIENCE *(check one)* ▶ ☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

▲ WHAT WENT WELL

▲ WHAT DIDN'T GO WELL

▲ HOW DID YOU FEEL DURING AND AFTER THE INFUSION?

Did you remember to drink a lot of water?

DAY BEFORE AND DAY OF INFUSION *(check one)* ▶ ☐ YES ☐ NO

IF YES, HOW MANY 8 OZ GLASSES? *(check one)* ▶ ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

DURING THE INFUSION *(check one)* ▶ ☐ YES ☐ NO

IF YES, HOW MANY GLASSES? *(check one)* ▶ ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

Did you remember to avoid caffeine/alcohol the day before and day of the infusion?

CAFFEINE *(check one)* ▶ ☐ YES ☐ NO
(coffee, tea, energy drinks, energy pills, or soft drinks)

ALCOHOL *(check one)* ▶ ☐ YES ☐ NO

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octagam® 10%
Immune Globulin Intravenous (Human) 10% Liquid Preparation

octagam® 5%
Immune Globulin Intravenous (Human) 5% Liquid Preparation

My IVIg infusion details

Did you have any symptoms? *(check all that apply)*

☐ **HEADACHE**

SEVERITY *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **FEVER**

WHAT WAS YOUR TEMPERATURE?

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **INCREASED HEART RATE**

WHAT WAS YOUR HEART RATE?

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **NAUSEA**

SEVERITY *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **PAIN**

WHERE WAS IT LOCATED?

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **FLU-LIKE SYMPTOMS**

SEVERITY *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

DESCRIBE OTHER SYMPTOMS AND WHAT ACTIONS YOU TOOK

CONTACT YOUR HEALTHCARE PROVIDER IF YOU ARE CONCERNED ABOUT ANY SYMPTOMS

QUESTIONS FOR YOUR NURSE OR DOCTOR

NEXT INFUSION DATE

REVIEW YOUR TREATMENT EXPERIENCE WITH YOUR NURSE OR DOCTOR

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octagam® 5%
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My IVIg infusion details

▲ **DATE** *(month/day/year)* ▲ **INFUSION NUMBER**

▲ **OCTAGAM 10% OR OCTAGAM 5% LOT NUMBER** **LOCATION** *(check one)* ▶ ☐ **HOME** ☐ **INFUSION CENTER**

▲ **INFUSION START TIME** *(am/pm)* ▲ **INFUSION END TIME** *(am/pm)* ▲ **INFUSION DURATION** *(hr/min)*

OVERALL EXPERIENCE *(check one)* ▶ ☐ **EXCELLENT** ☐ **VERY GOOD** ☐ **GOOD** ☐ **FAIR** ☐ **POOR**

MONITORING EXPERIENCE *(check one)* ▶ ☐ **EXCELLENT** ☐ **VERY GOOD** ☐ **GOOD** ☐ **FAIR** ☐ **POOR**

▲ **WHAT WENT WELL**

▲ **WHAT DIDN'T GO WELL**

▲ **HOW DID YOU FEEL DURING AND AFTER THE INFUSION?**

Did you remember to drink a lot of water?

DAY BEFORE AND DAY OF INFUSION *(check one)* ▶ ☐ **YES** ☐ **NO**

IF YES, HOW MANY 8 OZ GLASSES? *(check one)* ▶ ☐ **1-2** ☐ **3-5** ☐ **6-8** ☐ **MORE**

DURING THE INFUSION *(check one)* ▶ ☐ **YES** ☐ **NO**

IF YES, HOW MANY GLASSES? *(check one)* ▶ ☐ **1-2** ☐ **3-5** ☐ **6-8** ☐ **MORE**

Did you remember to avoid caffeine/alcohol the day before and day of the infusion?

CAFFEINE *(check one)* ▶ ☐ **YES** ☐ **NO**
(coffee, tea, energy drinks, energy pills, or soft drinks)

ALCOHOL *(check one)* ▶ ☐ **YES** ☐ **NO**

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Immune Globulin Intravenous (Human) 5% Liquid Preparation

My IVIg infusion details

Did you have any symptoms? *(check all that apply)*

☐ **HEADACHE**

▼ **SEVERITY** *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

▲ **WHEN DID IT START?**
(before/during/after infusion)

▲ **HOW LONG DID IT LAST?**
(approximate duration)

▲ **WHAT DID YOU DO ABOUT IT?**

☐ **FEVER**

▲ **WHAT WAS YOUR TEMPERATURE?**

▲ **WHEN DID IT START?**
(before/during/after infusion)

▲ **HOW LONG DID IT LAST?**
(approximate duration)

▲ **WHAT DID YOU DO ABOUT IT?**

☐ **INCREASED HEART RATE**

▲ **WHAT WAS YOUR HEART RATE?**

▲ **WHEN DID IT START?**
(before/during/after infusion)

▲ **HOW LONG DID IT LAST?**
(approximate duration)

▲ **WHAT DID YOU DO ABOUT IT?**

☐ **NAUSEA**

▼ **SEVERITY** *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

▲ **WHEN DID IT START?**
(before/during/after infusion)

▲ **HOW LONG DID IT LAST?**
(approximate duration)

▲ **WHAT DID YOU DO ABOUT IT?**

☐ **PAIN**

▲ **WHERE WAS IT LOCATED?**

▲ **WHEN DID IT START?**
(before/during/after infusion)

▲ **HOW LONG DID IT LAST?**
(approximate duration)

▲ **WHAT DID YOU DO ABOUT IT?**

☐ **FLU-LIKE SYMPTOMS**

▼ **SEVERITY** *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

▲ **WHEN DID IT START?**
(before/during/after infusion)

▲ **HOW LONG DID IT LAST?**
(approximate duration)

▲ **WHAT DID YOU DO ABOUT IT?**

▲ **DESCRIBE OTHER SYMPTOMS AND WHAT ACTIONS YOU TOOK**

CONTACT YOUR HEALTHCARE PROVIDER IF YOU ARE CONCERNED ABOUT ANY SYMPTOMS

▲ **QUESTIONS FOR YOUR NURSE OR DOCTOR**

▲ **NEXT INFUSION DATE**

REVIEW YOUR TREATMENT EXPERIENCE WITH YOUR NURSE OR DOCTOR

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My IVIg infusion details

▲ **DATE** *(month/day/year)* ▲ **INFUSION NUMBER**

▲ **OCTAGAM 10% OR OCTAGAM 5% LOT NUMBER** **LOCATION** *(check one)* ▶ ☐ **HOME** ☐ **INFUSION CENTER**

▲ **INFUSION START TIME** *(am/pm)* ▲ **INFUSION END TIME** *(am/pm)* ▲ **INFUSION DURATION** *(hr/min)*

OVERALL EXPERIENCE *(check one)* ▶ ☐ **EXCELLENT** ☐ **VERY GOOD** ☐ **GOOD** ☐ **FAIR** ☐ **POOR**

MONITORING EXPERIENCE *(check one)* ▶ ☐ **EXCELLENT** ☐ **VERY GOOD** ☐ **GOOD** ☐ **FAIR** ☐ **POOR**

▲ **WHAT WENT WELL**

▲ **WHAT DIDN'T GO WELL**

▲ **HOW DID YOU FEEL DURING AND AFTER THE INFUSION?**

Did you remember to drink a lot of water?

DAY BEFORE AND DAY OF INFUSION *(check one)* ▶ ☐ **YES** ☐ **NO**

IF YES, HOW MANY 8 OZ GLASSES? *(check one)* ▶ ☐ **1-2** ☐ **3-5** ☐ **6-8** ☐ **MORE**

DURING THE INFUSION *(check one)* ▶ ☐ **YES** ☐ **NO**

IF YES, HOW MANY GLASSES? *(check one)* ▶ ☐ **1-2** ☐ **3-5** ☐ **6-8** ☐ **MORE**

Did you remember to avoid caffeine/alcohol the day before and day of the infusion?

CAFFEINE *(check one)* ▶ ☐ **YES** ☐ **NO**
(coffee, tea, energy drinks, energy pills, or soft drinks)

ALCOHOL *(check one)* ▶ ☐ **YES** ☐ **NO**

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My IVIg infusion details

Did you have any symptoms? *(check all that apply)*

☐ **HEADACHE**

▼ **SEVERITY** *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

▲ **WHEN DID IT START?**
(before/during/after infusion)

▲ **HOW LONG DID IT LAST?**
(approximate duration)

▲ **WHAT DID YOU DO ABOUT IT?**

☐ **FEVER**

▲ **WHAT WAS YOUR TEMPERATURE?**

▲ **WHEN DID IT START?**
(before/during/after infusion)

▲ **HOW LONG DID IT LAST?**
(approximate duration)

▲ **WHAT DID YOU DO ABOUT IT?**

☐ **INCREASED HEART RATE**

▲ **WHAT WAS YOUR HEART RATE?**

▲ **WHEN DID IT START?**
(before/during/after infusion)

▲ **HOW LONG DID IT LAST?**
(approximate duration)

▲ **WHAT DID YOU DO ABOUT IT?**

☐ **NAUSEA**

▼ **SEVERITY** *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

▲ **WHEN DID IT START?**
(before/during/after infusion)

▲ **HOW LONG DID IT LAST?**
(approximate duration)

▲ **WHAT DID YOU DO ABOUT IT?**

☐ **PAIN**

▲ **WHERE WAS IT LOCATED?**

▲ **WHEN DID IT START?**
(before/during/after infusion)

▲ **HOW LONG DID IT LAST?**
(approximate duration)

▲ **WHAT DID YOU DO ABOUT IT?**

☐ **FLU-LIKE SYMPTOMS**

▼ **SEVERITY** *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

▲ **WHEN DID IT START?**
(before/during/after infusion)

▲ **HOW LONG DID IT LAST?**
(approximate duration)

▲ **WHAT DID YOU DO ABOUT IT?**

▲ **DESCRIBE OTHER SYMPTOMS AND WHAT ACTIONS YOU TOOK**

CONTACT YOUR HEALTHCARE PROVIDER IF YOU ARE CONCERNED ABOUT ANY SYMPTOMS

▲ **QUESTIONS FOR YOUR NURSE OR DOCTOR**

▲ **NEXT INFUSION DATE**

REVIEW YOUR TREATMENT EXPERIENCE WITH YOUR NURSE OR DOCTOR

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My IVIg infusion details

▲ DATE *(month/day/year)* ▲ INFUSION NUMBER

▲ OCTAGAM 10% OR OCTAGAM 5% LOT NUMBER LOCATION *(check one)* ▶ ☐ HOME ☐ INFUSION CENTER

▲ INFUSION START TIME *(am/pm)* ▲ INFUSION END TIME *(am/pm)* ▲ INFUSION DURATION *(hr/min)*

OVERALL EXPERIENCE *(check one)* ▶ ☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

MONITORING EXPERIENCE *(check one)* ▶ ☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

▲ WHAT WENT WELL

▲ WHAT DIDN'T GO WELL

▲ HOW DID YOU FEEL DURING AND AFTER THE INFUSION?

Did you remember to drink a lot of water?

DAY BEFORE AND DAY OF INFUSION *(check one)* ▶ ☐ YES ☐ NO

IF YES, HOW MANY 8 OZ GLASSES? *(check one)* ▶ ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

DURING THE INFUSION *(check one)* ▶ ☐ YES ☐ NO

IF YES, HOW MANY GLASSES? *(check one)* ▶ ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

Did you remember to avoid caffeine/alcohol the day before and day of the infusion?

CAFFEINE *(check one)* ▶ ☐ YES ☐ NO
(coffee, tea, energy drinks, energy pills, or soft drinks)

ALCOHOL *(check one)* ▶ ☐ YES ☐ NO

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My IVIg infusion details

Did you have any symptoms? *(check all that apply)*

☐ **HEADACHE**

SEVERITY *(check one)*
(1=mild to 5=very severe)
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WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
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WHAT DID YOU DO ABOUT IT?

☐ **FEVER**

WHAT WAS YOUR TEMPERATURE?

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **INCREASED HEART RATE**

WHAT WAS YOUR HEART RATE?

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **NAUSEA**

SEVERITY *(check one)*
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(approximate duration)

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WHERE WAS IT LOCATED?

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(before/during/after infusion)

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(1=mild to 5=very severe)
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HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

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NEXT INFUSION DATE

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My IVIg infusion details

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▲ INFUSION START TIME *(am/pm)* ▲ INFUSION END TIME *(am/pm)* ▲ INFUSION DURATION *(hr/min)*

OVERALL EXPERIENCE *(check one)* ▶ ☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

MONITORING EXPERIENCE *(check one)* ▶ ☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

▲ WHAT WENT WELL

▲ WHAT DIDN'T GO WELL

▲ HOW DID YOU FEEL DURING AND AFTER THE INFUSION?

Did you remember to drink a lot of water?

DAY BEFORE AND DAY OF INFUSION *(check one)* ▶ ☐ YES ☐ NO

IF YES, HOW MANY 8 OZ GLASSES? *(check one)* ▶ ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

DURING THE INFUSION *(check one)* ▶ ☐ YES ☐ NO

IF YES, HOW MANY GLASSES? *(check one)* ▶ ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

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(coffee, tea, energy drinks, energy pills, or soft drinks)

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(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

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WHAT WAS YOUR TEMPERATURE?

WHEN DID IT START?
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HOW LONG DID IT LAST?
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WHAT WAS YOUR HEART RATE?

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(approximate duration)

WHAT DID YOU DO ABOUT IT?

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HOW LONG DID IT LAST?
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My IVIg infusion details

▲ DATE *(month/day/year)* ▲ INFUSION NUMBER

▲ OCTAGAM 10% OR OCTAGAM 5% LOT NUMBER LOCATION *(check one)* ▶ ☐ HOME ☐ INFUSION CENTER

▲ INFUSION START TIME *(am/pm)* ▲ INFUSION END TIME *(am/pm)* ▲ INFUSION DURATION *(hr/min)*

OVERALL EXPERIENCE *(check one)* ▶ ☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

MONITORING EXPERIENCE *(check one)* ▶ ☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

▲ WHAT WENT WELL

▲ WHAT DIDN'T GO WELL

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Did you remember to drink a lot of water?

DAY BEFORE AND DAY OF INFUSION *(check one)* ▶ ☐ YES ☐ NO

IF YES, HOW MANY 8 OZ GLASSES? *(check one)* ▶ ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

DURING THE INFUSION *(check one)* ▶ ☐ YES ☐ NO

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(before/during/after infusion)

HOW LONG DID IT LAST?
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WHAT DID YOU DO ABOUT IT?

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WHAT WAS YOUR TEMPERATURE?

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HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **INCREASED HEART RATE**

WHAT WAS YOUR HEART RATE?

WHEN DID IT START?
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HOW LONG DID IT LAST?
(approximate duration)

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WHEN DID IT START?
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WHAT DID YOU DO ABOUT IT?

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My IVIg infusion details

▲ DATE *(month/day/year)* ▲ INFUSION NUMBER

▲ OCTAGAM 10% OR OCTAGAM 5% LOT NUMBER LOCATION *(check one)* ▶ ☐ HOME ☐ INFUSION CENTER

▲ INFUSION START TIME *(am/pm)* ▲ INFUSION END TIME *(am/pm)* ▲ INFUSION DURATION *(hr/min)*

OVERALL EXPERIENCE *(check one)* ▶ ☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

MONITORING EXPERIENCE *(check one)* ▶ ☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

▲ WHAT WENT WELL

▲ WHAT DIDN'T GO WELL

▲ HOW DID YOU FEEL DURING AND AFTER THE INFUSION?

Did you remember to drink a lot of water?

DAY BEFORE AND DAY OF INFUSION *(check one)* ▶ ☐ YES ☐ NO

IF YES, HOW MANY 8 OZ GLASSES? *(check one)* ▶ ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

DURING THE INFUSION *(check one)* ▶ ☐ YES ☐ NO

IF YES, HOW MANY GLASSES? *(check one)* ▶ ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

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CAFFEINE *(check one)* ▶ ☐ YES ☐ NO
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ALCOHOL *(check one)* ▶ ☐ YES ☐ NO

Please see Full Prescribing Information, including complete BOXED WARNING, available here for OCTAGAM 10% or here for OCTAGAM 5%.

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Immune Globulin Intravenous (Human) 10% Liquid Preparation

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My IVIg infusion details

Did you have any symptoms? *(check all that apply)*

☐ **HEADACHE**

SEVERITY *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **FEVER**

WHAT WAS YOUR TEMPERATURE?

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **INCREASED HEART RATE**

WHAT WAS YOUR HEART RATE?

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **NAUSEA**

SEVERITY *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **PAIN**

WHERE WAS IT LOCATED?

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

☐ **FLU-LIKE SYMPTOMS**

SEVERITY *(check one)*
(1=mild to 5=very severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

WHEN DID IT START?
(before/during/after infusion)

HOW LONG DID IT LAST?
(approximate duration)

WHAT DID YOU DO ABOUT IT?

DESCRIBE OTHER SYMPTOMS AND WHAT ACTIONS YOU TOOK

CONTACT YOUR HEALTHCARE PROVIDER IF YOU ARE CONCERNED ABOUT ANY SYMPTOMS

QUESTIONS FOR YOUR NURSE OR DOCTOR

NEXT INFUSION DATE

REVIEW YOUR TREATMENT EXPERIENCE WITH YOUR NURSE OR DOCTOR

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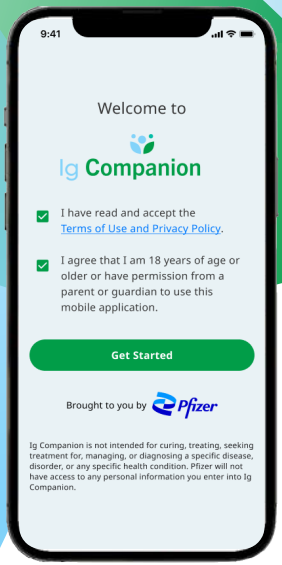

Ig Companion

Pfizer is committed to providing tools and resources to help support patients on Ig therapy

Ig Companion is a free mobile app designed to complement the treatment experience for patients and caregivers and help prepare them for doctor visits

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Key features of the Ig Companion free mobile app include helping patients:

- Navigate through the infusion process
- Access educational content
- Track, manage, and export infusion information
- Set reminders for events

Ig Companion is not intended for curing, treating, seeking treatment for, managing, or diagnosing a specific disease, disorder, or any specific health condition. Pfizer will not have access to any personal information you enter into Ig Companion.

Available for free download from the App Store and Google Play.

Download on the App Store

GET IT ON Google Play

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What to expect from your IVIg therapy

Being prepared and knowing what to expect can be helpful

GETTING READY FOR YOUR INFUSION

Make sure to drink a lot of water the day before and the day of your IVIg therapy, and avoid caffeine and alcohol

Have an activity available to help pass the time (eg, reading a book)

DURING AND AFTER YOUR INFUSION

Your IVIg therapy will be given through a needle inserted into your vein

Your blood pressure and temperature will be checked during treatment

Your infusion time will vary and could take several hours

You can continue with the regular activities of your day, as tolerated

Call your doctor, nurse, or pharmacist with any questions, or if you have side effects

Patients should always ask their doctors for medical advice about adverse events.

You may report an adverse event related to Pfizer products by calling 1-800-438-1985 (US only). If you prefer, you may contact the US Food and Drug Administration (FDA) directly. The FDA has established a reporting service known as MedWatch where healthcare professionals and consumers can report problems they suspect may be associated with the drugs and medical devices they prescribe, dispense, or use. Visit www.fda.gov/MedWatch or call 1-800-FDA-1088.

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