My PANZYGA Therapy Tracker

panzyga®

Immune Globulin
Intravenous (Human) - ifas
10% Liquid Preparation

{ pronounced: *pan-zee-guh* }

Please click here for Full Prescribing Information, including complete BOXED WARNING.

INDICATION AND USAGE

PANZYGA (Immune Globulin Intravenous [Human] – ifas) is indicated for the treatment of primary humoral immunodeficiency (PI) in patients 2 years of age and older, chronic immune thrombocytopenia (cITP) in adults and chronic inflammatory demyelinating polyneuropathy (CIDP) in adults. PANZYGA is a liquid medicine for infusion that contains immunoglobulin G (IgG). It is made from human plasma that is donated by healthy people and contains antibodies that replace the missing antibodies in patients with PI or ITP. In patients with CIDP, these antibodies block the body from attacking its own nerve cells.

PANZYGA is given into a vein (intravenously) in a hospital, infusion center, doctor's office, or at home by a trained healthcare provider (HCP).

PANZYGA is a liquid medicine for infusion that contains immunoglobulin G (IgG), which are proteins that help fight infection. PANZYGA is used to treat patients 2 years of age and older with PI, adults with cITP, and adults with CIDP.

IMPORTANT SAFETY INFORMATION

WARNING: THROMBOSIS, RENAL DYSFUNCTION, and ACUTE RENAL FAILURE
See full prescribing information for complete BOXED WARNING

- **Thrombosis may occur with immune globulin intravenous (IGIV) products, including PANZYGA. Risk factors may include: advanced age, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling vascular catheters, hyperviscosity, and cardiovascular risk factors.**
- **Renal dysfunction, acute renal failure, osmotic nephropathy, and death may occur with the administration of IGIV products in predisposed patients. Renal dysfunction and acute renal failure occur more commonly in patients receiving IGIV products containing sucrose. PANZYGA does not contain sucrose.**
- **For patients at risk of thrombosis, renal dysfunction, or acute renal failure, administer PANZYGA at the minimum infusion rate practicable. Ensure adequate hydration in patients before administration. Monitor for signs and symptoms of thrombosis and assess blood viscosity in patients at risk for hyperviscosity.**

Please click here for Full Prescribing Information, including complete BOXED WARNING.

IMPORTANT SAFETY INFORMATION (continued)

Do not use PANZYGA if you:

- Have had a severe allergic reaction to immune globulin or other blood products
- Have a condition called selective (or severe) immunoglobulin A (IgA) deficiency, with antibodies against IgA and a history of hypersensitivity

What should I avoid while taking PANZYGA?

- PANZYGA can make vaccines (like measles/mumps/rubella or chickenpox vaccines) work less effectively for you. Before you get any vaccines, tell your healthcare provider that you take PANZYGA
- Decreased kidney function and kidney function failure can occur
- Severe headache, drowsiness, fever, painful eye movements, or nausea and vomiting can occur
- Elevated blood pressure can occur particularly in patients who have a history of hypertension (high blood pressure)
- If you are elderly, with heart or kidney problems, discuss with your healthcare provider prior to initiating treatment with PANZYGA
- PANZYGA is made from human blood and therefore may have a risk of transmitting infectious agents, including viruses and, theoretically, the variant Creutzfeldt-Jakob disease (CJD) and CJD agent. The production and manufacturing process reduces this risk, but the risk cannot be eliminated

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PANZYGA can cause serious side effects. If any of the following problems occur after starting PANZYGA, stop the infusion immediately and contact your HCP or call emergency services:

- Hives, swelling in the mouth or throat, itching, trouble breathing, wheezing, fainting, or dizziness. These could be signs of a serious allergic reaction
- Bad headache with nausea, vomiting, stiff neck, fever, drowsiness, painful eye movements, and sensitivity to light. These could be signs of irritation and swelling of the lining around your brain
- Reduced urination, sudden weight gain, or swelling in your legs. These could be signs of a kidney problem (decreased kidney function or kidney failure)
- Pain, swelling, warmth, redness, or a lump in your legs or arms. These could be signs of a blood clot, which could happen in the heart, brain, lungs, or elsewhere in the body
- Brown or red urine, swelling, fatigue, fast heart rate, difficulty breathing, or yellow skin or eyes. These could be signs of a liver or blood problem
- Chest pain or trouble breathing, or blue lips or extremities. These could be signs of a serious heart or lung problem
- Fever over 100°F. This could be a sign of an infection
- Headache, fatigue or confusion, vision problem, chest pain, difficulty breathing, irregular heartbeat, or pounding in your chest, neck, or ears. These could be signs of high blood pressure

IMPORTANT SAFETY INFORMATION (continued)

Ask your HCP whether you should have rescue medications available, such as antihistamines or epinephrine.

What are the possible or reasonably likely side effects for PANZYGA?

The most common side effects that may occur with PANZYGA are:

- Headache
- Nausea
- Fever
- Increased blood pressure
- Dermatitis
- Fatigue
- Abdominal pain
- Dizziness
- Anemia

These are not all the possible side effects. Talk to your HCP about any side effect that bothers you or that does not go away.

Tell your HCP if you are pregnant, or plan to become pregnant, or if you are nursing.

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My PANZYGA Therapy Tracker

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Why do I need to record my intravenous immunoglobulin (IVIg) treatment experience?

The PANZYGA Therapy Tracker can help you record your infusion experience with IVIg treatment. This record is an important part of helping your healthcare team better understand how your IVIg treatment is progressing.

After each infusion, you and your infusion nurse can take a moment to record your infusion experience. Your notes will help show your treatment team what is going well or if they should make any adjustments. It will also help you and your doctor to keep track of your progress over time.

DIRECTIONS

Make one entry for each infusion. Remember to write down the date and the time you start and end each infusion. Each page includes brief questions to help guide you in your note-taking. You also have space to jot down any questions you may have for your treatment team.

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

Please click here for Full Prescribing Information, including complete BOXED WARNING.

▲ NAME ▲ MEDICAL CONDITION (CIDP, PI, cITP, OR OTHER)

LOCATION *(check one)* → ☐ HOME ☐ INFUSION CENTER ☐ HOSPITAL

▲ SPECIAL NOTES/ADDITIONAL INFORMATION

LIST ALL CURRENT MEDICATIONS (INCLUDING OVER-THE-COUNTER, VITAMINS, AND SUPPLEMENTS)

IN CASE OF EMERGENCY, DIAL 911

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

My PANZYGA Infusion Details

panzyga®
Immune Globulin Intravenous (Human) - ifas 10% Liquid Preparation

▲ **DATE** (month / day / year)

▲ **INFUSION NUMBER**

▲ **DOSE** (gm or mL)

▲ **PANZYGA LOT NUMBER**

LOCATION *(check one)* → ☐ HOME ☐ INFUSION CENTER ☐ HOSPITAL

▲ **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 INFUSION?**

Did you remember to drink plenty of fluids?

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 8 OZ GLASSES? *(check one)* → ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

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

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

ALCOHOL *(check one)* → ☐ YES ☐ NO

Please click here for Full Prescribing Information, including complete BOXED WARNING.

Did you have any side effects? *(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 (BPM)?**

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

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

▲ **WHAT DID YOU DO ABOUT IT?**

☐ SKIN INFLAMMATION

▼ **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?**

☐ 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?**

☐ FATIGUE

▼ **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?**

☐ 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?**

☐ DIZZINESS

▼ **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 ANY OTHER SYMPTOMS AND WHAT ACTIONS YOU TOOK**

CONTACT YOUR HEALTHCARE PROVIDER IF YOU ARE CONCERNED

▲ **QUESTIONS FOR YOUR DOCTOR, NURSE, OR PHARMACIST**

▲ **NEXT INFUSION**

REVIEW WITH YOUR TREATMENT TEAM

My PANZYGA Infusion Details

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▲ **DATE** (month / day / year)

▲ **INFUSION NUMBER**

▲ **DOSE** (gm or mL)

▲ **PANZYGA LOT NUMBER**

LOCATION *(check one)* → ☐ HOME ☐ INFUSION CENTER ☐ HOSPITAL

▲ **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 INFUSION?**

Did you remember to drink plenty of fluids?

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 8 OZ GLASSES? *(check one)* → ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

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

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

ALCOHOL *(check one)* → ☐ YES ☐ NO

Please click here for Full Prescribing Information, including complete BOXED WARNING.

Did you have any side effects? *(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 (BPM)?**

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

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

▲ **WHAT DID YOU DO ABOUT IT?**

☐ SKIN INFLAMMATION

▼ **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?**

☐ 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?**

☐ FATIGUE

▼ **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?**

☐ 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?**

☐ DIZZINESS

▼ **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 ANY OTHER SYMPTOMS AND WHAT ACTIONS YOU TOOK**

CONTACT YOUR HEALTHCARE PROVIDER IF YOU ARE CONCERNED

▲ **QUESTIONS FOR YOUR DOCTOR, NURSE, OR PHARMACIST**

▲ **NEXT INFUSION**

REVIEW WITH YOUR TREATMENT TEAM

My PANZYGA Infusion Details

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▲ **DATE** (month / day / year)

▲ **INFUSION NUMBER**

▲ **DOSE** (gm or mL)

▲ **PANZYGA LOT NUMBER**

LOCATION *(check one)* → ☐ HOME ☐ INFUSION CENTER ☐ HOSPITAL

▲ **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 INFUSION?**

Did you remember to drink plenty of fluids?

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 8 OZ GLASSES? *(check one)* → ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

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

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

ALCOHOL *(check one)* → ☐ YES ☐ NO

Please click here for Full Prescribing Information, including complete BOXED WARNING.

Did you have any side effects? *(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 (BPM)?**

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

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

▲ **WHAT DID YOU DO ABOUT IT?**

☐ SKIN INFLAMMATION

▼ **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?**

☐ 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?**

☐ FATIGUE

▼ **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?**

☐ 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?**

☐ DIZZINESS

▼ **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 ANY OTHER SYMPTOMS AND WHAT ACTIONS YOU TOOK**

CONTACT YOUR HEALTHCARE PROVIDER IF YOU ARE CONCERNED

▲ **QUESTIONS FOR YOUR DOCTOR, NURSE, OR PHARMACIST**

▲ **NEXT INFUSION**

REVIEW WITH YOUR TREATMENT TEAM

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▲ **DATE** (month / day / year)

▲ **INFUSION NUMBER**

▲ **DOSE** (gm or mL)

▲ **PANZYGA LOT NUMBER**

LOCATION *(check one)* → ☐ HOME ☐ INFUSION CENTER ☐ HOSPITAL

▲ **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 INFUSION?**

Did you remember to drink plenty of fluids?

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 8 OZ GLASSES? *(check one)* → ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

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

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

ALCOHOL *(check one)* → ☐ YES ☐ NO

Please click here for Full Prescribing Information, including complete BOXED WARNING.

Did you have any side effects? *(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 (BPM)?**

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

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

▲ **WHAT DID YOU DO ABOUT IT?**

☐ SKIN INFLAMMATION

▼ **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?**

☐ 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?**

☐ FATIGUE

▼ **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?**

☐ 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?**

☐ DIZZINESS

▼ **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 ANY OTHER SYMPTOMS AND WHAT ACTIONS YOU TOOK**

CONTACT YOUR HEALTHCARE PROVIDER IF YOU ARE CONCERNED

▲ **QUESTIONS FOR YOUR DOCTOR, NURSE, OR PHARMACIST**

▲ **NEXT INFUSION**

REVIEW WITH YOUR TREATMENT TEAM

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Immune Globulin Intravenous (Human) - ifas 10% Liquid Preparation

▲ **DATE** (month / day / year)

▲ **INFUSION NUMBER**

▲ **DOSE** (gm or mL)

▲ **PANZYGA LOT NUMBER**

LOCATION *(check one)* → ☐ HOME ☐ INFUSION CENTER ☐ HOSPITAL

▲ **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 INFUSION?**

Did you remember to drink plenty of fluids?

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 8 OZ GLASSES? *(check one)* → ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

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

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

ALCOHOL *(check one)* → ☐ YES ☐ NO

Please click here for Full Prescribing Information, including complete BOXED WARNING.

Did you have any side effects? *(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 (BPM)?**

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

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

▲ **WHAT DID YOU DO ABOUT IT?**

☐ SKIN INFLAMMATION

▼ **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?**

☐ 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?**

☐ FATIGUE

▼ **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?**

☐ 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?**

☐ DIZZINESS

▼ **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 ANY OTHER SYMPTOMS AND WHAT ACTIONS YOU TOOK**

CONTACT YOUR HEALTHCARE PROVIDER IF YOU ARE CONCERNED

▲ **QUESTIONS FOR YOUR DOCTOR, NURSE, OR PHARMACIST**

▲ **NEXT INFUSION**

REVIEW WITH YOUR TREATMENT TEAM

My PANZYGA Infusion Details

panzyga®
Immune Globulin Intravenous (Human) - ifas 10% Liquid Preparation

▲ **DATE** (month / day / year)

▲ **INFUSION NUMBER**

▲ **DOSE** (gm or mL)

▲ **PANZYGA LOT NUMBER**

LOCATION *(check one)* → ☐ HOME ☐ INFUSION CENTER ☐ HOSPITAL

▲ **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 INFUSION?**

Did you remember to drink plenty of fluids?

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 8 OZ GLASSES? *(check one)* → ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

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

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

ALCOHOL *(check one)* → ☐ YES ☐ NO

Please click here for Full Prescribing Information, including complete BOXED WARNING.

Did you have any side effects? *(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 (BPM)?**

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

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

▲ **WHAT DID YOU DO ABOUT IT?**

☐ SKIN INFLAMMATION

▼ **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?**

☐ 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?**

☐ FATIGUE

▼ **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?**

☐ 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?**

☐ DIZZINESS

▼ **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 ANY OTHER SYMPTOMS AND WHAT ACTIONS YOU TOOK**

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Immune Globulin Intravenous (Human) - ifas 10% Liquid Preparation

▲ **DATE** (month / day / year)

▲ **INFUSION NUMBER**

▲ **DOSE** (gm or mL)

▲ **PANZYGA LOT NUMBER**

LOCATION *(check one)* → ☐ HOME ☐ INFUSION CENTER ☐ HOSPITAL

▲ **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 INFUSION?**

Did you remember to drink plenty of fluids?

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 8 OZ GLASSES? *(check one)* → ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

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

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

ALCOHOL *(check one)* → ☐ YES ☐ NO

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Did you have any side effects? *(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 (BPM)?**

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

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

▲ **WHAT DID YOU DO ABOUT IT?**

☐ SKIN INFLAMMATION

▼ **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?**

☐ 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?**

☐ FATIGUE

▼ **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?**

☐ 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?**

☐ DIZZINESS

▼ **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 ANY OTHER SYMPTOMS AND WHAT ACTIONS YOU TOOK**

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▲ **DATE** (month / day / year)

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▲ **DOSE** (gm or mL)

▲ **PANZYGA LOT NUMBER**

LOCATION *(check one)* → ☐ HOME ☐ INFUSION CENTER ☐ HOSPITAL

▲ **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 INFUSION?**

Did you remember to drink plenty of fluids?

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 8 OZ GLASSES? *(check one)* → ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

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

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

ALCOHOL *(check one)* → ☐ YES ☐ NO

Please click here for Full Prescribing Information, including complete BOXED WARNING.

Did you have any side effects? *(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 (BPM)?**

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

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

▲ **WHAT DID YOU DO ABOUT IT?**

☐ SKIN INFLAMMATION

▼ **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?**

☐ 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?**

☐ FATIGUE

▼ **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?**

☐ 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?**

☐ DIZZINESS

▼ **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 ANY OTHER SYMPTOMS AND WHAT ACTIONS YOU TOOK**

CONTACT YOUR HEALTHCARE PROVIDER IF YOU ARE CONCERNED

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▲ **NEXT INFUSION**

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Immune Globulin Intravenous (Human) - ifas 10% Liquid Preparation

▲ **DATE** (month / day / year)

▲ **INFUSION NUMBER**

▲ **DOSE** (gm or mL)

▲ **PANZYGA LOT NUMBER**

LOCATION *(check one)* → ☐ HOME ☐ INFUSION CENTER ☐ HOSPITAL

▲ **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 INFUSION?**

Did you remember to drink plenty of fluids?

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 8 OZ GLASSES? *(check one)* → ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

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

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

ALCOHOL *(check one)* → ☐ YES ☐ NO

Please click here for Full Prescribing Information, including complete BOXED WARNING.

Did you have any side effects? *(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 (BPM)?**

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

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

▲ **WHAT DID YOU DO ABOUT IT?**

☐ SKIN INFLAMMATION

▼ **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?**

☐ 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?**

☐ FATIGUE

▼ **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?**

☐ 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?**

☐ DIZZINESS

▼ **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?**
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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 INFUSION?**

Did you remember to drink plenty of fluids?

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 8 OZ GLASSES? *(check one)* → ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

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

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

ALCOHOL *(check one)* → ☐ YES ☐ NO

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Did you have any side effects? *(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 (BPM)?**

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

▲ **WHAT DID YOU DO ABOUT IT?**

☐ SKIN INFLAMMATION

▼ **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?**

☐ 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?**

☐ FATIGUE

▼ **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?**

☐ 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?**

☐ DIZZINESS

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

▲ **WHEN DID IT START?**
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▲ **HOW LONG DID IT LAST?**
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▲ **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 INFUSION?**

Did you remember to drink plenty of fluids?

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 8 OZ GLASSES? *(check one)* → ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

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

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

ALCOHOL *(check one)* → ☐ YES ☐ NO

Please click here for Full Prescribing Information, including complete BOXED WARNING.

Did you have any side effects? *(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 (BPM)?**

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

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

▲ **WHAT DID YOU DO ABOUT IT?**

☐ SKIN INFLAMMATION

▼ **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?**

☐ 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?**

☐ FATIGUE

▼ **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?**

☐ 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?**

☐ DIZZINESS

▼ **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 ANY OTHER SYMPTOMS AND WHAT ACTIONS YOU TOOK**

CONTACT YOUR HEALTHCARE PROVIDER IF YOU ARE CONCERNED

▲ **QUESTIONS FOR YOUR DOCTOR, NURSE, OR PHARMACIST**

▲ **NEXT INFUSION**

REVIEW WITH YOUR TREATMENT TEAM

My PANZYGA Infusion Details

panzyga®
Immune Globulin Intravenous (Human) - ifas 10% Liquid Preparation

▲ **DATE** (month / day / year)

▲ **INFUSION NUMBER**

▲ **DOSE** (gm or mL)

▲ **PANZYGA LOT NUMBER**

LOCATION *(check one)* ➔ ☐ HOME ☐ INFUSION CENTER ☐ HOSPITAL

▲ **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 INFUSION?**

Did you remember to drink plenty of fluids?

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 8 OZ GLASSES? *(check one)* ➔ ☐ 1-2 ☐ 3-5 ☐ 6-8 ☐ MORE

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

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

ALCOHOL *(check one)* ➔ ☐ YES ☐ NO

Please click here for Full Prescribing Information, including complete BOXED WARNING.

Did you have any side effects? *(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 (BPM)?**

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

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

▲ **WHAT DID YOU DO ABOUT IT?**

☐ SKIN INFLAMMATION

▼ **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?**

☐ 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?**

☐ FATIGUE

▼ **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?**

☐ 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?**

☐ DIZZINESS

▼ **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 ANY OTHER SYMPTOMS AND WHAT ACTIONS YOU TOOK**

CONTACT YOUR HEALTHCARE PROVIDER IF YOU ARE CONCERNED

▲ **QUESTIONS FOR YOUR DOCTOR, NURSE, OR PHARMACIST**

▲ **NEXT INFUSION**

REVIEW WITH YOUR TREATMENT TEAM

What to expect from your IVIg treatment

Being prepared and knowing what to expect can be helpful.

GETTING READY FOR YOUR INFUSION

- Make sure to stay well hydrated the day before and the day of your IVIg therapy
- Have something with you to help pass the time
- Avoid caffeine and alcohol during this time—they can cause dehydration

DURING AND AFTER YOUR INFUSION

- Your IVIg therapy will be given as an infusion 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 become worried about 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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