Reconnect with friends over dinner.

People with PI who infuse CUVITRU may be able to experience more of these moments with weekly or every-other-week infusions.

This is your Wellness Journal.

Use this to record your infusions and keep track of how you’re feeling throughout the process.

What is CUVITRU® [Immune Globulin Subcutaneous (Human)] 20% Solution?

CUVITRU is a ready-to-use liquid medicine that is given under the skin (subcutaneously) to treat primary immunodeficiency (PI) in people 2 years and older.

IMPORTANT SAFETY INFORMATION

What is the most important information I need to know about CUVITRU?

CUVITRU can cause the following serious reactions:

- Severe allergic reactions causing difficulty in breathing or skin rashes
- Decreased kidney function or kidney failure
- Blood clots in the heart, brain, lungs, or elsewhere in the body
- Severe headache, drowsiness, fever, painful eye movements, or nausea and vomiting
- Dark colored urine, swelling, fatigue, or difficulty breathing

Please scroll for additional Important Safety Information, click for Information For Patients, and discuss with your HCP.
Let’s track your treatment together.

Thank you for trusting CUVITRU to help you manage and treat your primary immunodeficiency (PI).

Keeping a record of your infusions is an important part of staying on track with your treatment plan. And with this Wellness Journal, we’re here to help you do just that. Whether you’re infusing daily, weekly or twice a month—use this journal to log each infusion, document how you’re feeling during or after your infusion, and write down any questions, concerns or thoughts you want to talk to your doctor about.

We’re here to help.
Resources and support are available. See page 115 for information about co-pay and community support.

IMPORTANT SAFETY INFORMATION (continued)

Who should not use CUVITRU?
Do not use CUVITRU 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.

Please scroll for additional Important Safety Information, click for Information For Patients, including Warning about Blood Clots, and discuss with your HCP.
Write down your details.

This basic information will help get your Wellness Journal off to a good start.

This infusion log is the property of:

Name: __________________________________________

Phone: __________________________________________

Medication allergy: __________________________________________

Date I was diagnosed with PI: ____________________________

Date I started my treatment: ____________________________

What I want from this therapy: __________________________________________

Brand of my infusion pump: __________________________________________

Healthcare contacts:

Keep this info handy so you’re not scrambling for phone numbers when you need them.

Doctor

Name: __________________________________________

Phone: __________________________________________

Nurse

Name: __________________________________________

Phone: __________________________________________

Specialty pharmacy

Name: __________________________________________

Phone: __________________________________________

Insurance

Name: __________________________________________

Phone: __________________________________________
What the infusion experience is like.

**BEFORE the infusion**
- Get comfy
- Get your supplies out and ready
- Read over the infusion steps as a refresher if you need to, especially if you're just starting out
- If appropriate, make sure you're hydrated before infusing and have a drink nearby in case you're thirsty during your infusion
- If others are around, let them know your infusion time so there's as little disruption for you as possible

**DURING the infusion**
- Try your best to relax and stay comfy, as the average infusion time is about 2 hours
- Read, play a game, catch up on your fave show, call a friend, get creative and use this time for you
- You may experience mild to moderate pain, redness, swelling, and itching (BUT, these are common and generally go away within a few hours). These aren't all of the possible side effects, but ones you may immediately notice
- Other common side effects may include headache, nausea, fatigue, diarrhea, fever, and vomiting
- These are not all the possible side effects. Talk to your doctor about any side effect that bothers you or that does not go away. If side effects increase in severity or persist more than a few days, call your doctor or hospital emergency services immediately
- For additional safety information, click for Information for Patients

**AFTER the infusion**
- If appropriate, continue to drink fluids to stay hydrated
- Record your infusion details and any reactions or notes for yourself or your doctor

**IMPORTANT SAFETY INFORMATION (continued)**

**What should I avoid while taking CUVITRU?**
- CUVITRU can make vaccines (like measles/mumps/rubella or chickenpox vaccines) not work as well for you. Before you get any vaccines, tell your healthcare provider (HCP) that you take CUVITRU.
- Tell your HCP if you are pregnant, or plan to become pregnant, or if you are nursing.

Please scroll for additional Important Safety Information, click for Information For Patients, including Warning about Blood Clots, and discuss with your HCP.
How to use this journal.

Use your Wellness Journal to track your treatment.

Your Wellness Journal serves two purposes—to maintain a log of your infusions and to keep track of your day-to-day wellness. Keeping a record of all your infusions and how you’re feeling is important for you and your doctor to monitor your health.

As soon as you complete each infusion, just fill in the information required to log that infusion.

Mark down whether your infusion is daily, weekly, or twice a month.

Keep track of IG vial information here. You can either remove the label or write in the information.

Add date to this square.

Document how you feel before, after, and in between your infusions by using the scale.

Use the space below to add any notes.

Mark any pages you want to talk over with your doctor or nurse.
Infusion 1

Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Your weight: ____________________________(lb)

Start time: ____________________________ (AM/PM)

Dose: ____________________________ (g)

Infusion rate (highest rate tolerated):

___________________________ mL/hr

Stop time: ____________________________ (AM/PM)

Duration of infusion:

___________________________ hr ___________________________ min

Rotate your site(s) between future infusions.

Questions to discuss with your healthcare team:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Infusion schedule: ________________________________

Record any changes in the supplies you used for this infusion:

____________________________________________________________________

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____________________________________________________________________

List medication(s) taken prior to infusion:

____________________________________________________________________

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List any reactions during and after your infusion:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

Affix the label here or write in:

Lot number:________________________

Vial size:________________________

Expiration date:_____/_____/_____

Affix the label here or write in:

Lot number:________________________

Vial size:________________________

Expiration date:_____/_____/_____

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Vial size:________________________

Expiration date:_____/_____/_____

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Lot number:________________________

Vial size:________________________

Expiration date:_____/_____/_____
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</table>

Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
**Infusion 2**

**Date of infusion:** ________ / ________ / ________  
Mark an X to show the site(s) of this infusion.

**Infusion schedule:** _________________________  
Record any changes in the supplies you used for this infusion:

__________________________________________  
__________________________________________  
__________________________________________  
__________________________________________  

**Your weight:** ______________________________ (lb)  
**Start time:** ________________________________ (AM/PM)  
**Dose:** ________________________________ (g)  
**Infusion rate (highest rate tolerated):**  
__________________________________________ mL/hr  
**Stop time:** ________________________________ (AM/PM)  
**Duration of infusion:**  
__________________________________________ hr  
__________________________________________ min  

*Rotate your site(s) between future infusions.*

**Questions to discuss with your healthcare team:**

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**Infusion schedule:** _________________________  
List medication(s) taken prior to infusion:

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**Infusion schedule:** _________________________  
List any reactions during and after your infusion:

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*Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.*

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

---

**Infusion 2**

**Date of infusion:** ________ / ________ / ________  
Infusion schedule: _________________________  
Mark an X to show the site(s) of this infusion.

**Infusion schedule:** _________________________  
Record any changes in the supplies you used for this infusion:

__________________________________________  
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__________________________________________  

**Your weight:** ______________________________ (lb)  
**Start time:** ________________________________ (AM/PM)  
**Dose:** ________________________________ (g)  
**Infusion rate (highest rate tolerated):**  
__________________________________________ mL/hr  
**Stop time:** ________________________________ (AM/PM)  
**Duration of infusion:**  
__________________________________________ hr  
__________________________________________ min  

*Rotate your site(s) between future infusions.*

**Questions to discuss with your healthcare team:**

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**Infusion schedule:** _________________________  
List medication(s) taken prior to infusion:

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**Infusion schedule:** _________________________  
List any reactions during and after your infusion:

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*Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.*

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

---

**Infusion schedule:** _________________________  
List medication(s) taken prior to infusion:

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**Infusion schedule:** _________________________  
List any reactions during and after your infusion:

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*Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.*

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

---

**Infusion schedule:** _________________________  
List medication(s) taken prior to infusion:

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**Infusion schedule:** _________________________  
List any reactions during and after your infusion:

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*Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.*

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

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**Affix the label here or write in:**

**Lot number:**

**Vial size:**

**Expiration date:**_____/_____/______

**Affix the label here or write in:**

**Lot number:**

**Vial size:**

**Expiration date:**_____/_____/______

**Affix the label here or write in:**

**Lot number:**

**Vial size:**

**Expiration date:**_____/_____/______

**Affix the label here or write in:**

**Lot number:**

**Vial size:**

**Expiration date:**_____/_____/______

**Affix the label here or write in:**

**Lot number:**

**Vial size:**

**Expiration date:**_____/_____/______
Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

---

**Wellness Tracker for Infusion 2**

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<th>Month: ___________________</th>
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<th>Rate your overall wellness: — ☻ ☻ ☻ ☻ ☻ +</th>
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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Infusion 3

Date of infusion: ________ / ________ / ________
Mark an X to show the site(s) of this infusion.

Infusion schedule: _________________________
Record any changes in the supplies you used for this infusion:

Your weight: ____________________________ (lb)
Start time: ______________________________ (AM/PM)
Dose: ________________________________ (g)
Infusion rate (highest rate tolerated):
_____________________________ mL/hr
Stop time: ______________________________ (AM/PM)
Duration of infusion:
_____________________________ hr ________________ min

Rotate your site(s) between future infusions.

List medication(s) taken prior to infusion:

List any reactions during and after your infusion:

Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

**Affix the label here** or write in:
Lot number: __________________________
Vial size: __________________________
Expiration date: ______/_____/______

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Lot number: __________________________
Vial size: __________________________
Expiration date: ______/_____/______
Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

[Diagram of arm and leg with X marks]

Your weight: ________________________________ (lb)

Start time: ________________________________ (AM/PM)

Dose: ________________________________ (g)

Infusion rate (highest rate tolerated):

________________________________________ mL/hr

Stop time: ________________________________ (AM/PM)

Duration of infusion:

________________________________________ hr __________________________________ min

Rotate your site(s) between future infusions.

Infusion schedule: __________________________

Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

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Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

**Affix the label here** or write in:

Lot number: __________________________

Vial size: __________________________

Expiration date: _____/____/____

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Vial size: __________________________

Expiration date: _____/____/____

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Expiration date: _____/____/____

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Vial size: __________________________

Expiration date: _____/____/____
### Wellness Tracker for Infusion 4

**Month:** ___________________  **Year:** ___________________  **Rate your overall wellness:** — ☹ ☹ ☹ ☺ ☻ ☼ ☽ +

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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Infusion 5

Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

Affix the label here or write in:
Lot number: ____________________
Vial size: ____________________
Expiration date: _____/_____/_____

Affix the label here or write in:
Lot number: ____________________
Vial size: ____________________
Expiration date: _____/_____/_____

Affix the label here or write in:
Lot number: ____________________
Vial size: ____________________
Expiration date: _____/_____/_____

Affix the label here or write in:
Lot number: ____________________
Vial size: ____________________
Expiration date: _____/_____/_____

Infusion schedule: _________________________

Record any changes in the supplies you used for this infusion:

________________________________________
________________________________________
________________________________________
________________________________________

List medication(s) taken prior to infusion:

________________________________________
________________________________________
________________________________________
________________________________________

List any reactions during and after your infusion:

________________________________________
________________________________________
________________________________________
________________________________________

Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Your weight: ____________________________ (lb)

Start time: ______________________________ (AM/PM)

Dose: ____________________________ (g)

Infusion rate (highest rate tolerated):

____________________________ mL/hr

Stop time: ______________________________ (AM/PM)

Duration of infusion:

____________________________ hr ________________ min

Rotate your site(s) between future infusions.

Questions to discuss with your healthcare team:

________________________________________
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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

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Month: ___________________   Year: ___________________   Rate your overall wellness: — 🙂 🙂 🙂 🙂 😞

Wellness Tracker for Infusion 5
Date of infusion: ________ /________ /________

Infusion schedule: _________________________

Your weight: ____________________________ (lb)

Start time: ____________________________ (AM/PM)

Dose: ____________________________ (g)

Infusion rate (highest rate tolerated): ________ mL/hr

Stop time: ____________________________ (AM/PM)

Duration of infusion: ________ hr ________ min

Rotate your site(s) between future infusions.

Infusion 6

Questions to discuss with your healthcare team:

________________________________________________________________________

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

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Vial size: __________________________
Expiration date: _____/_____/_____

Affix the label here or write in:
Lot number: __________________________
Vial size: __________________________
Expiration date: _____/_____/_____

Affix the label here or write in:
Lot number: __________________________
Vial size: __________________________
Expiration date: _____/_____/_____

Affix the label here or write in:
Lot number: __________________________
Vial size: __________________________
Expiration date: _____/_____/_____

Affix the label here or write in:
Lot number: __________________________
Vial size: __________________________
Expiration date: _____/_____/_____

Affix the label here or write in:
Lot number: __________________________
Vial size: __________________________
Expiration date: _____/_____/_____

List medication(s) taken prior to infusion:
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List any reactions during and after your infusion:
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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Infusion schedule: _________________________

Record any changes in the supplies you used for this infusion:

Affix the label here or write in:
Lot number:________________________
Vial size:________________________
Expiration date:_____/_____/______

Affix the label here or write in:
Lot number:________________________
Vial size:________________________
Expiration date:_____/_____/______

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Lot number:________________________
Vial size:________________________
Expiration date:_____/_____/______

Affix the label here or write in:
Lot number:________________________
Vial size:________________________
Expiration date:_____/_____/______

Affix the label here or write in:
Lot number:________________________
Vial size:________________________
Expiration date:_____/_____/______

Your weight:________________________ (lb)

Start time:________________________ (AM/PM)

Dose:________________________ (g)

Infusion rate (highest rate tolerated):
________________________ mL/hr

Stop time:________________________ (AM/PM)

Duration of infusion:
________________________ hr ____________________ min

Rotate your site(s) between future infusions.

Questions to discuss with your healthcare team:

List medication(s) taken prior to infusion:

List any reactions during and after your infusion:

Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.
Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Date of infusion: ________ / _______ / _______

Mark an X to show the site(s) of this infusion.

Infusion schedule: _________________________

Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

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Your weight: __________________________ (lb)

Start time: ____________________________ (AM/PM)

Dose: ________________________________ (g)

Infusion rate (highest rate tolerated):

____________________________________ mL/hr

Stop time: ____________________________ (AM/PM)

Duration of infusion:

____________________________________ hr ________________________ min

Rotate your site(s) between future infusions.

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

Affix the label here or write in:

Lot number:

Vial size:

Expiration date:

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Affix the label here or write in:

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Expiration date:

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Affix the label here or write in:

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Vial size:

Expiration date:

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Affix the label here or write in:

Lot number:

Vial size:

Expiration date:

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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

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<th>Sunday</th>
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</thead>
</table>

Month: ___________________   Year: ___________________ Rate your overall wellness: —○○○○○ ○
Infusion 9

Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Infusion schedule: _________________________

Your weight: ____________________________ (lb)

Start time: _____________________________ (AM/PM)

Dose: ________________________________ (g)

Infusion rate (highest rate tolerated):

________________________________________ mL/hr

Stop time: _____________________________ (AM/PM)

Duration of infusion:

________________________________________ hr __________________________ min

Rotate your site(s) between future infusions.

Questions to discuss with your healthcare team:

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Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

Affix the label here or write in:

Lot number:__________________________

Vial size:___________________________

Expiration date:_____/_____/______

Affix the label here or write in:

Lot number:__________________________

Vial size:___________________________

Expiration date:_____/_____/______

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Lot number:__________________________

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Expiration date:_____/_____/______

Affix the label here or write in:

Lot number:__________________________

Vial size:___________________________

Expiration date:_____/_____/______
Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Your weight: ________________________________ (lb)

Start time: ________________________________(AM/PM)

Dose: ________________________________ (g)

Infusion rate (highest rate tolerated):
__________________________ mL/hr

Stop time: ________________________________(AM/PM)

Duration of infusion:
__________________________ hr ____________ min

Rotate your site(s) between future infusions.

Infusion schedule: _________________________

Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

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Affix the label here or write in:

Lot number: ____________________________

Vial size: ____________________________

Expiration date: _____/____/____

Affix the label here or write in:

Lot number: ____________________________

Vial size: ____________________________

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Lot number: ____________________________

Vial size: ____________________________

Expiration date: _____/____/____

Affix the label here or write in:

Lot number: ____________________________

Vial size: ____________________________

Expiration date: _____/____/____
Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
**Infusion 11**

**Date of infusion:** ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Your weight: __________________________ (lb)

Start time: ____________________________ (AM/PM)

Dose: ____________________________ (g)

Infusion rate (highest rate tolerated):

__________________________ mL/hr

Stop time: ____________________________ (AM/PM)

Duration of infusion:

__________________________ hr _________________ min

Rotate your site(s) between future infusions.

**Infusion schedule:** _________________________

Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
**Infusion 12**

**Date of infusion:** _______ / _______ / _______

Mark an X to show the site(s) of this infusion.

![Image of infusion sites]

**Infusion schedule:** _______________________

Record any changes in the supplies you used for this infusion:

- _____________________________
- _____________________________
- _____________________________
- _____________________________

List medication(s) taken prior to infusion:

- _____________________________
- _____________________________
- _____________________________
- _____________________________

List any reactions during and after your infusion:

- _____________________________
- _____________________________
- _____________________________
- _____________________________

Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

**Your weight:** ____________________________ (lb)

**Start time:** ____________________________ (AM/PM)

**Dose:** ____________________________ (g)

**Infusion rate (highest rate tolerated):** ____________________________ mL/hr

**Stop time:** ____________________________ (AM/PM)

**Duration of infusion:** ____________________________ hr ____________________________ min

Rotate your site(s) between future infusions.

**Questions to discuss with your healthcare team:**

- _____________________________
- _____________________________
- _____________________________
- _____________________________

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

**Affix the label here or write in:**

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<th>Lot number:</th>
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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

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**Wellness Tracker for Infusion 12**

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Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Your weight: ____________________________ (lb)

Start time: ____________________________ (AM/PM)

Dose: ________________________________ (g)

Infusion rate (highest rate tolerated):

____________________________________ mL/hr

Stop time: ____________________________ (AM/PM)

Duration of infusion:

____________________________________ hr ____________________ min

Rotate your site(s) between future infusions.

Infusion schedule: _________________________________

Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

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Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

Affix the label here or write in:

Lot number: __________________________

Vial size: ____________________________

Expiration date: _______/_____/______

Affix the label here or write in:

Lot number: __________________________

Vial size: ____________________________

Expiration date: _______/_____/______

Affix the label here or write in:

Lot number: __________________________

Vial size: ____________________________

Expiration date: _______/_____/______

Affix the label here or write in:

Lot number: __________________________

Vial size: ____________________________

Expiration date: _______/_____/______
Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Your weight: __________________________ (lb)

Start time: ____________________________ (AM/PM)

Dose: ________________________________ (g)

Infusion rate (highest rate tolerated):

____________________________________ mL/hr

Stop time: ____________________________ (AM/PM)

Duration of infusion:

____________________________________ hr __________________________ min

Rotate your site(s) between future infusions.

Infusion schedule: ____________________________

Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

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Affix the label here or write in:

Lot number: __________________________

Vial size: ____________________________

Expiration date: _____/____/____

Affix the label here or write in:

Lot number: __________________________

Vial size: ____________________________

Expiration date: _____/____/____

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Lot number: __________________________

Vial size: ____________________________

Expiration date: _____/____/____

Affix the label here or write in:

Lot number: __________________________

Vial size: ____________________________

Expiration date: _____/____/____
### Wellness Tracker for Infusion 14

<table>
<thead>
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<th>Month: ___________________</th>
<th>Year: ___________________</th>
<th>Rate your overall wellness: —— —— —— —— —— +</th>
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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Date of infusion: ________ /________ /________

Mark an X to show the site(s) of this infusion.

Your weight: ________________________(lb)

Start time: ________________________(AM/PM)

Dose: _____________________________(g)

Infusion rate (highest rate tolerated):

______________________________________mL/hr

Stop time: ________________________(AM/PM)

Duration of infusion:

_________________________________________ hr ____________________________ min

Rotate your site(s) between future infusions.

Infusion schedule: _________________________

Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

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Affix the label here or write in:

Lot number:__________________________

Vial size:____________________________

Expiration date:_____/_____/_____

Affix the label here or write in:

Lot number:__________________________

Vial size:____________________________

Expiration date:_____/_____/_____

Affix the label here or write in:

Lot number:__________________________

Vial size:____________________________

Expiration date:_____/_____/_____

Affix the label here or write in:

Lot number:__________________________

Vial size:____________________________

Expiration date:_____/_____/_____
Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

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Rate your overall wellness: 📌😊😊😊😊
Date of infusion: ________ /________ /________

Mark an X to show the site(s) of this infusion.

Infusion schedule: _________________________

Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

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Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

Affix the label here or write in:

Lot number:
Vial size:
Expiration date:_____/_____/_____

Affix the label here or write in:

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Expiration date:_____/_____/_____

Affix the label here or write in:

Lot number:
Vial size:
Expiration date:_____/_____/_____

Affix the label here or write in:

Lot number:
Vial size:
Expiration date:_____/_____/_____

Your weight:_______________________________ (lb)
Start time:_______________________________(AM/PM)
Dose:_______________________________ (g)
Infusion rate (highest rate tolerated):
________________________________________ mL/hr
Stop time:_______________________________(AM/PM)
Duration of infusion:
________________________________________ hr __________________________ min

Rotate your site(s) between future infusions.

List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Wellness Tracker for Infusion 16

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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Infusion 17

Date of infusion: ________ /________ /________

Mark an X to show the site(s) of this infusion.

Your weight: ____________________________ (lb)

Start time: ____________________________ (AM/PM)

Dose: ______________________________ (g)

Infusion rate (highest rate tolerated):

_____________________________ mL/hr

Stop time: ____________________________ (AM/PM)

Duration of infusion:

_____________________________ hr________________________ min

Rotate your site(s) between future infusions.

Infusion schedule: _________________________

Record any changes in the supplies you used for this infusion:

__________________________________________

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__________________________________________

List medication(s) taken prior to infusion:

__________________________________________

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

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Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

Affix the label here or write in:

Lot number: ____________________________

Vial size: ____________________________

Expiration date: ______/____/____

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Vial size: ____________________________

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Vial size: ____________________________

Expiration date: ______/____/____

Affix the label here or write in:

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Vial size: ____________________________

Expiration date: ______/____/____
Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

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Rate your overall wellness: – 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 🌡️🌡️🌡️ | 🌡️🌡️🌡️ | 🌡️🌡️🌡️ | 🌡️🌡️🌡️ | 🌡️🌡️🌡️ | 🌡️🌡️🌡️ | 🌡️🌡️🌡️ |

Month: ___________________   Year: ___________________
Infusion 18

**Date of infusion:** ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

![Site Diagram]

**Infusion schedule:** _________________________

Record any changes in the supplies you used for this infusion:


**Your weight:** ______________________________ (lb)

**Start time:** ________________________________ (AM/PM)

**Dose:** ________________________________ (g)

**Infusion rate (highest rate tolerated):**

__________________________________________ mL/hr

**Stop time:** ________________________________ (AM/PM)

**Duration of infusion:**

__________________________________________ hr _________________ min

*Rotate your site(s) between future infusions.*

**Questions to discuss with your healthcare team:**

_____________________________________________________________________

_____________________________________________________________________

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 Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

**Affix the label here or write in:**

Lot number:__________________________

Vial size:__________________________

Expiration date:______ / _____ / _____

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Vial size:__________________________

Expiration date:______ / _____ / _____

**Affix the label here or write in:**

Lot number:__________________________

Vial size:__________________________

Expiration date:______ / _____ / _____

**Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.**

Record any changes in the supplies you used for this infusion:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

List medication(s) taken prior to infusion:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

List any reactions during and after your infusion:

_____________________________________________________________________

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List any reactions during and after your infusion:

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List any reactions during and after your infusion:

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List any reactions during and after your infusion:

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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Infusion 19

Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Your weight: ________________________________ (lb)

Start time: ________________________________ (AM/PM)

Dose: ________________________________ (g)

Infusion rate (highest rate tolerated):

________________________________________ mL/hr

Stop time: ________________________________ (AM/PM)

Duration of infusion:

________________________________________ hr ______________________ min

Rotate your site(s) between future infusions.

Infusion schedule: ________________________________

Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

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Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

**Affix the label here** or write in:

Lot number: __________________________

Vial size: __________________________

Expiration date: _____/_____/______

**Affix the label here** or write in:

Lot number: __________________________

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Expiration date: _____/_____/______

**Affix the label here** or write in:

Lot number: __________________________

Vial size: __________________________

Expiration date: _____/_____/______
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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

Rate your overall wellness: 

Month: ___________________ Year: ___________________
Infusion 20

Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Your weight: ___________________________ (lb)

Start time: ____________________________ (AM/PM)

Dose: ___________________________ (g)

Infusion rate (highest rate tolerated):

__________________________________________ mL/hr

Stop time: ____________________________ (AM/PM)

Duration of infusion:

________________________________________ hr _________________ min

Rotate your site(s) between future infusions.

Infusion schedule: ____________________________

Record any changes in the supplies you used for this infusion:

__________________________________________

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__________________________________________

List medication(s) taken prior to infusion:

__________________________________________

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__________________________________________

List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

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Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

**Affix the label here** or write in:

Lot number:_____________________

Vial size:_____________________

Expiration date:_____/_____/_____

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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Infusion schedule: _________________________

Record any changes in the supplies you used for this infusion:

Affix the label here or write in:
Lot number:__________________________
Vial size:____________________________
Expiration date:_____/_____/______

Infusion rate (highest rate tolerated):
____________________________________ mL/hr

List medication(s) taken prior to infusion:
____________________________________

List any reactions during and after your infusion:
____________________________________

Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Your weight:____________________________(lb)

Start time:______________________________(AM/PM)

Dose:__________________________(g)

Stop time:______________________________(AM/PM)

Duration of infusion:
____________________________________ hr _____________ min

Rotate your site(s) between future infusions.

Questions to discuss with your healthcare team:

Affix the label here or write in:
Lot number:__________________________
Vial size:____________________________
Expiration date:_____/_____/______

Affix the label here or write in:
Lot number:__________________________
Vial size:____________________________
Expiration date:_____/_____/______

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Expiration date:_____/_____/______
Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Date of infusion: ________ / ________ / ________

Infusion schedule: _________________________

Mark an X to show the site(s) of this infusion.

Your weight: _____________________________ (lb)

Start time: _____________________________ (AM/PM)

Dose: ____________________________________ (g)

Infusion rate (highest rate tolerated):

________________________________________ mL/hr

Stop time: _____________________________ (AM/PM)

Duration of infusion:

________________________ hr __________________________ min

Rotate your site(s) between future infusions.

Questions to discuss with your healthcare team:

________________________________________

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Infusion 22

Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

Affix the label here or write in:

Lot number:

Vial size:

Expiration date:______/______/______

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Lot number:

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Expiration date:______/______/______

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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Your weight: ___________________________ (lb)

Start time: ___________________________ (AM/PM)

Dose: ___________________________ (g)

Infusion rate (highest rate tolerated):

_________________________ mL/hr

Stop time: ___________________________ (AM/PM)

Duration of infusion:

_________________________ hr ________________________ min

Rotate your site(s) between future infusions.

Infusion schedule: ________________________________

Record any changes in the supplies you used for this infusion:

________________________________________________

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List medication(s) taken prior to infusion:

________________________________________________

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

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Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

**Affix the label here** or write in:

Lot number: ___________________________

Vial size: ___________________________

Expiration date: ______/_____/_____

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Lot number: ___________________________

Vial size: ___________________________

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Lot number: ___________________________

Vial size: ___________________________

Expiration date: ______/_____/_____
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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

Month: ___________________   Year: ___________________   Rate your overall wellness: —〇〇〇〇〇〇〇+
Infusion 24

Date of infusion: ________ /________ /________

Mark an X to show the site(s) of this infusion.

Your weight: __________________________ (lb)

Start time: ____________________________(AM/PM)

Dose: ________________________________ (g)

Infusion rate (highest rate tolerated):
________________________________________ mL/hr

Stop time: ____________________________(AM/PM)

Duration of infusion:
________________________________________ hr __________________________ min

Rotate your site(s) between future infusions.

Infusion schedule: ________________________________

Record any changes in the supplies you used for this infusion:

________________________________________

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________________________________________

List medication(s) taken prior to infusion:

________________________________________

________________________________________

________________________________________

List any reactions during and after your infusion:

________________________________________

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________________________________________

Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

________________________________________

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Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

Affix the label here or write in:

Lot number:__________________________

Vial size:___________________________

Expiration date:_____/_____/______

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Lot number:__________________________

Vial size:___________________________

Expiration date:_____/_____/______

Affix the label here or write in:

Lot number:__________________________

Vial size:___________________________

Expiration date:_____/_____/______

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Lot number:__________________________

Vial size:___________________________

Expiration date:_____/_____/______
Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Date of infusion: ________ /________ /________

Mark an X to show the site(s) of this infusion.

Infusion schedule: _________________________

Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Rotate site(s) between future infusions.

Questions to discuss with your healthcare team:

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Affix the label here or write in:

Lot number:____________________
Vial size:____________________
Expiration date:____/____/____

List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Your weight:____________________ (lb)

Start time:____________________ (AM/PM)

Dose:____________________ (g)

Infusion rate (highest rate tolerated):

________________________________ ml/hr

Stop time:____________________ (AM/PM)

Duration of infusion:

________________________________ hr ____________________ min

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.
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**Wellness Tracker for Infusion 25**

**Month:** ___________________  **Year:** ___________________  **Rate your overall wellness:** — ☣️ ☣️ ☣️ ☣️ ☣️

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Infusion 26

**Date of infusion:** ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

- ![Diagram of infusion sites]

**Infusion schedule:** _________________________

Record any changes in the supplies you used for this infusion:

- _________________________
- _________________________
- _________________________
- _________________________

List medication(s) taken prior to infusion:

- _________________________
- _________________________
- _________________________
- _________________________

List any reactions during and after your infusion:

- _________________________
- _________________________
- _________________________
- _________________________

Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

**Your weight:** _____________________________ (lb)

**Start time:** _____________________________ (AM/PM)

**Dose:** _____________________________ (g)

**Infusion rate (highest rate tolerated):**

- _____________________________ mL/hr

**Stop time:** _____________________________ (AM/PM)

**Duration of infusion:**

- _____________________________ hr _____________________________ min

**Rotate your site(s) between future infusions.**

**Questions to discuss with your healthcare team:**

- _________________________
- _________________________
- _________________________
- _________________________

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

**Affix the label here or write in:**

- **Lot number:** _________________________
- **Vial size:** _________________________
- **Expiration date:** _____ / _____ / _____

**Affix the label here or write in:**

- **Lot number:** _________________________
- **Vial size:** _________________________
- **Expiration date:** _____ / _____ / _____

**Affix the label here or write in:**

- **Lot number:** _________________________
- **Vial size:** _________________________
- **Expiration date:** _____ / _____ / _____

**Affix the label here or write in:**

- **Lot number:** _________________________
- **Vial size:** _________________________
- **Expiration date:** _____ / _____ / _____
Wellness Tracker for Infusion 26

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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

Rate your overall wellness: 

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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

---

Month: ___________________   Year: ___________________
Infusion 27

Date of infusion: ________ / ________ / ________
Mark an X to show the site(s) of this infusion.

Infusion schedule: _________________________
Record any changes in the supplies you used for this infusion:

Infusion rate (highest rate tolerated):
______________________________________ mL/hr

Start time: ____________________________ (AM/PM)

Stop time: ____________________________ (AM/PM)

Duration of infusion:
______________________________________ hr ________________________ min

Your weight: ___________________________ (lb)

Dose: ___________________________ (g)

List medication(s) taken prior to infusion:
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______________________________________
______________________________________

List any reactions during and after your infusion:
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Questions to discuss with your healthcare team:
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Rotate your site(s) between future infusions.

Affix the label here or write in:
Lot number: _________________________
Vial size: _________________________
Expiration date: _____ / ____ / ____

Affix the label here or write in:
Lot number: _________________________
Vial size: _________________________
Expiration date: _____ / ____ / ____

Affix the label here or write in:
Lot number: _________________________
Vial size: _________________________
Expiration date: _____ / ____ / ____

Affix the label here or write in:
Lot number: _________________________
Vial size: _________________________
Expiration date: _____ / ____ / ____

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.
Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

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Month: ___________________   Year: ___________________   Rate your overall wellness: ☹☹☹☹☹☹+
Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Infusion schedule: _________________________

Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Your weight: _____________________________ (lb)

Start time: _____________________________ (AM/PM)

Dose: _____________________________ (g)

Infusion rate (highest rate tolerated):

__________________________ mL/hr

Stop time: _____________________________ (AM/PM)

Duration of infusion:

__________________________ hr ____________________________ min

Rotate your site(s) between future infusions.

Questions to discuss with your healthcare team:

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Affix the label here or write in:

Lot number: _____________________________

Vial size: _____________________________

Expiration date: _____/____/____

Affix the label here or write in:

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Expiration date: _____/____/____
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Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Infusion schedule: _________________________

Your weight: ____________________________ (lb)

Start time: ____________________________ (AM/PM)

Dose: ____________________________ (g)

Infusion rate (highest rate tolerated):

________________________________ mL/hr

Stop time: ____________________________ (AM/PM)

Duration of infusion:

________________________________ hr ____________________________ min

Rotate your site(s) between future infusions.

Questions to discuss with your healthcare team:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Record any changes in the supplies you used for this infusion:

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Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

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Lot number:__________________________

Vial size:__________________________

Expiration date:_____/_____/______

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Vial size:__________________________

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Lot number:__________________________

Vial size:__________________________

Expiration date:_____/_____/______

**Affix the label here** or write in:

Lot number:__________________________

Vial size:__________________________

Expiration date:_____/_____/______

List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

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Rate your overall wellness:  

63
Date of infusion: ________ / ________ / ________

Infusion schedule: _________________________

Mark an X to show the site(s) of this infusion.

Your weight: ________________________________(lb)

Start time: ________________________________(AM/PM)

Dose: ________________________________(g)

Infusion rate (highest rate tolerated):

_________________________________________ mL/hr

Stop time: ________________________________(AM/PM)

Duration of infusion:

_________________________________________ hr ___________________________ min

Rotate your site(s) between future infusions.

Infusion schedule: _________________________

Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Date of infusion: ________ / ________ / ________
Mark an X to show the site(s) of this infusion.

Your weight: ____________________________ (lb)

Start time: ____________________________ (AM/PM)

Dose: ________________________________ (g)

Infusion rate (highest rate tolerated):

________________________________________ mL/hr

Stop time: ____________________________ (AM/PM)

Duration of infusion:

________________________ hr ____________ min

Rotate your site(s) between future infusions.

Infusion schedule: __________________________

Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

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Affix the label here or write in:

Lot number:__________________________
Vial size:__________________________
Expiration date:_____/_____/_____

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Rate your overall wellness: — [ ] [ ] [ ] [ ] [ ] [ ] [ ]
Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Infusion schedule: _________________________

Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Infusion rate (highest rate tolerated):

_________ mL/hr

Stop time: ________________________ (AM/PM)

Duration of infusion:

_________ hr _____________________ min

Rotate your site(s) between future infusions.

Your weight: __________________________ (lb)

Start time: ___________________________ (AM/PM)

Dose: ____________________________ (g)

Affix the label here or write in:

Lot number:__________________________
Vial size:____________________________
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Rate your overall wellness: [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Month: ___________________   Year: ___________________
Date of infusion: ________ / ________ / ________
Mark an X to show the site(s) of this infusion.

Infusion schedule: _________________________
Record any changes in the supplies you used for this infusion:

Your weight: ____________________________(lb)

Start time: ____________________________(AM/PM)

Dose: ________________________________(g)

Infusion rate (highest rate tolerated):
____________________________________ mL/hr

Stop time: ____________________________(AM/PM)

Duration of infusion:
____________________________________ hr ________________________ min

Rotate your site(s) between future infusions.

List medication(s) taken prior to infusion:
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List any reactions during and after your infusion:
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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:
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Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

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Vial size: _____________________________
Expiration date: ___/___/____

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Vial size: _____________________________
Expiration date: ___/___/____

Affix the label here or write in:
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Vial size: _____________________________
Expiration date: ___/___/____

Infusion 33
## Wellness Tracker for Infusion 33

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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Infusion schedule: _________________________

Record any changes in the supplies you used for this infusion:

Affix the label here or write in:
Lot number:_____________________
Vial size:_____________________
Expiration date:_____/_____/_____

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Affix the label here or write in:
Lot number:_____________________
Vial size:_____________________
Expiration date:_____/_____/_____

Your weight:________________________ (lb)

Start time:__________________________ (AM/PM)

Dose:______________________________ (g)

Infusion rate (highest rate tolerated):

________________________________________ mL/hr

Stop time:__________________________ (AM/PM)

Duration of infusion:

________________________________________ hr ______________________ min

Rotate your site(s) between future infusions.

List medication(s) taken prior to infusion:

List any reactions during and after your infusion:

Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

List medication(s) taken prior to infusion:

List any reactions during and after your infusion:

Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:
Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

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Infusion 35

Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Your weight: ____________________________ (lb)

Start time: ____________________________ (AM/PM)

Dose: ________________________________ (g)

Infusion rate (highest rate tolerated):
________________________________________ mL/hr

Stop time: ____________________________ (AM/PM)

Duration of infusion:
________________________________________ hr ____________________________ min

Rotate your site(s) between future infusions.

Infusion schedule: ____________________________

Record any changes in the supplies you used for this infusion:

________________________________________

________________________________________

List medication(s) taken prior to infusion:

________________________________________

________________________________________

List any reactions during and after your infusion:

________________________________________

________________________________________

Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

________________________________________

________________________________________

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________________________________________

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

Affix the label here or write in:

Lot number: ____________________________
Vial size: ____________________________
Expiration date: _____ / _____ / _____

Affix the label here or write in:

Lot number: ____________________________
Vial size: ____________________________
Expiration date: _____ / _____ / _____

Affix the label here or write in:

Lot number: ____________________________
Vial size: ____________________________
Expiration date: _____ / _____ / _____

Affix the label here or write in:

Lot number: ____________________________
Vial size: ____________________________
Expiration date: _____ / _____ / _____

Record any changes in the supplies you used for this infusion:

List medication(s) taken prior to infusion:

List any reactions during and after your infusion:

Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.
Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Infusion 36

Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Your weight: __________________________ (lb)

Start time: ___________________________ (AM/PM)

Dose: ________________________________ (g)

Infusion rate (highest rate tolerated):

__________________________ mL/hr

Stop time: ___________________________ (AM/PM)

Duration of infusion:

__________________________ hr ________________ min

Rotate your site(s) between future infusions.

Infusion schedule: __________________________

Record any changes in the supplies you used for this infusion:


List medication(s) taken prior to infusion:


List any reactions during and after your infusion:


Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:


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Lot number:________________________

Vial size:________________________

Expiration date:_____/_____/______

**Affix the label here or write in:**

Lot number:________________________

Vial size:________________________

Expiration date:_____/_____/______

**Affix the label here or write in:**

Lot number:________________________

Vial size:________________________

Expiration date:_____/_____/______

**Affix the label here or write in:**

Lot number:________________________

Vial size:________________________

Expiration date:_____/_____/______
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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Infusion schedule: _________________________

Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Affix the label here or write in:

Lot number:________________________
Vial size:________________________
Expiration date:____/____/____

Your weight:________________________ (lb)

Start time:________________________ (am/pm)

Dose:_______________________________ (g)

Infusion rate (highest rate tolerated):

_______________________________ mL/hr

Stop time:________________________ (am/pm)

Duration of infusion:

________________________ hr ____________ min

Rotate your site(s) between future infusions.

Questions to discuss with your healthcare team:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.
## Wellness Tracker for Infusion 37

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<th>Month: ___________________</th>
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<th>Rate your overall wellness: —— —— —— —— —— +</th>
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**Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.**
Date of infusion: ________ /________ /_______

Infusion schedule: _________________________

Mark an X to show the site(s) of this infusion.

Your weight: ________________________________(lb)

Start time: ________________________________(AM/PM)

Dose: ________________________________ (g)

Infusion rate (highest rate tolerated):

________________________ mL/hr

Stop time: ________________________________(AM/PM)

Duration of infusion:

________________________ hr ____________________ min

Rotate your site(s) between future infusions.

Questions to discuss with your healthcare team:

__________________________________________

__________________________________________

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Infusion schedule: _________________________

Record any changes in the supplies you used for this infusion:

__________________________________________

__________________________________________

__________________________________________

List any reactions during and after your infusion:

__________________________________________

__________________________________________

__________________________________________

Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Affix the label here or write in:

Lot number: ____________________________

Vial size: ______________________________

Expiration date: _____/_____/______

Affix the label here or write in:

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Vial size: ______________________________

Expiration date: _____/_____/______

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Lot number: ____________________________

Vial size: ______________________________

Expiration date: _____/_____/______
Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
**Date of infusion:** ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

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**Infusion schedule:** _________________________

Record any changes in the supplies you used for this infusion:

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**Infusion schedule:** _________________________

List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

**Your weight:** ___________________________ (lb)

**Start time:** __________________________ (AM/PM)

**Dose:** __________________________ (g)

**Infusion rate (highest rate tolerated):** ______________ mL/hr

**Stop time:** __________________________ (AM/PM)

**Duration of infusion:** __________________________ hr ______________ min

**Rotate your site(s) between future infusions.**

**Questions to discuss with your healthcare team:**

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Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

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- **Expiration date:** _____/_____/_____

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- **Vial size:** ______________
- **Expiration date:** _____/_____/_____

**Record any changes in the supplies you used for this infusion:**

**List medication(s) taken prior to infusion:**

**List any reactions during and after your infusion:**

**Questions to discuss with your healthcare team:**

**Date of infusion:** ________ / ________ / ________
### Wellness Tracker for Infusion 39

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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Infusion schedule: _________________________

Record any changes in the supplies you used for this infusion:

List medication(s) taken prior to infusion:

List any reactions during and after your infusion:

Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Your weight: ____________________________ (lb)

Start time: ____________________________ (AM/PM)

Dose: ____________________________ (g)

Infusion rate (highest rate tolerated):

__________________________ mL/hr

Stop time: ____________________________ (AM/PM)

Duration of infusion:

__________________________ hr _______________________ min

Rotate your site(s) between future infusions.

Questions to discuss with your healthcare team:

Affix the label here or write in:

Lot number: __________________

Vial size: __________________

Expiration date: _____/_____/_____

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

Affix the label here or write in:

Lot number: __________________

Vial size: __________________

Expiration date: _____/_____/_____

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Expiration date: _____/_____/_____

Affix the label here or write in:

Lot number: __________________

Vial size: __________________

Expiration date: _____/_____/_____
## Wellness Tracker for Infusion 40

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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Infusion schedule: _________________________

Your weight: __________________________ (lb)

Start time: __________________________ (AM/PM)

Dose: ________________________________ (g)

Infusion rate (highest rate tolerated):

_________________________________________ mL/hr

Stop time: __________________________ (AM/PM)

Duration of infusion:

_________________________ hr __________________________ min

Rotate your site(s) between future infusions.

Questions to discuss with your healthcare team:

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Infusion schedule: _________________________

Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

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Lot number: ________________

Vial size: ________________

Expiration date: ______/_____/_____
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Date of infusion: ________ /________ /________

Mark an X to show the site(s) of this infusion.

[Diagram showing sites for infusion]

Infusion schedule: _________________________

Record any changes in the supplies you used for this infusion:

<table>
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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

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Infusion 42

Your weight: ___________________________ (lb)

Start time: ____________________________ (AM/PM)

Dose: _________________________________ (g)

Infusion rate (highest rate tolerated):

____________________________________ mL/hr

Stop time: ____________________________ (AM/PM)

Duration of infusion:

________________________________________ hr _________________________ min

Rotate your site(s) between future infusions.
Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

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**Month:** ___________  **Year:** ___________  **Rate your overall wellness:**  —— ★★★★★
Date of infusion: ________ /________ /________

Mark an X to show the site(s) of this infusion.

Your weight: ____________________________ (lb)

Start time: ____________________________ (AM/PM)

Dose: ____________________________ (g)

Infusion rate (highest rate tolerated):

____________________________ mL/hr

Stop time: ____________________________ (AM/PM)

Duration of infusion:

________________________ hr ____________ min

Rotate your site(s) between future infusions.

Infusion schedule: __________________________

Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

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Vial size: ____________________________

Expiration date: _____/_____ /_____

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Lot number: ____________________________

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|        |        |        | Rate your overall wellness: — 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 😞 📝 Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor. 📝
Date of infusion: ________ / ________ / ________

Infusion schedule: _________________________

Your weight: ____________________________ (lb)

Start time: ____________________________ (AM/PM)

Dose: ________________________________ (g)

Infusion rate (highest rate tolerated):

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Duration of infusion:

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Rotate your site(s) between future infusions.

Questions to discuss with your healthcare team:

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Affix the label here or write in:

Lot number: ____________________________

Vial size: _____________________________

Expiration date: ______ / ______ / ______

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Lot number: ____________________________

Vial size: _____________________________

Expiration date: ______ / ______ / ______

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Expiration date: ______ / ______ / ______

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Expiration date: ______ / ______ / ______
Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

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Rate your overall wellness: ⭕️ ⭕️ ⭕️ ⭕️ +
**Infusion 45**

**Date of infusion:** ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

![Infusion Sites Diagram]

**Infusion schedule:** _________________________

Record any changes in the supplies you used for this infusion:

- ________________________________
- ________________________________
- ________________________________
- ________________________________

List medication(s) taken prior to infusion:

- ________________________________
- ________________________________
- ________________________________
- ________________________________

List any reactions during and after your infusion:

- ________________________________
- ________________________________
- ________________________________
- ________________________________

*Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.*

**Your weight:** _____________________________ (lb)

**Start time:** _____________________________ (AM/PM)

**Dose:** _________________________________ (g)

**Infusion rate (highest rate tolerated):**

_______________________________ mL/hr

**Stop time:** _____________________________ (AM/PM)

**Duration of infusion:**

_________________________ hr _____________ min

*Rotate your site(s) between future infusions.*

**Questions to discuss with your healthcare team:**

- ________________________________
- ________________________________
- ________________________________
- ________________________________

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

- **Affix the label here** or write in:
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Infusion 46

**Date of infusion:** ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

![Infusion Sites]

Your weight: ___________________________ (lb)

Start time: ____________________________ (AM/PM)

Dose: _________________________________ (g)

Infusion rate (highest rate tolerated):

______________________________________ mL/hr

Stop time: _____________________________ (AM/PM)

Duration of infusion:

__________________________ hr ____________________ min

Rotate your site(s) between future infusions.

**Infusion schedule:** _______________________

Record any changes in the supplies you used for this infusion:

___________________________________________

___________________________________________

___________________________________________

List medication(s) taken prior to infusion:

___________________________________________

___________________________________________

___________________________________________

List any reactions during and after your infusion:

___________________________________________

___________________________________________

___________________________________________

**Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.**

**Questions to discuss with your healthcare team:**

___________________________________________

___________________________________________

___________________________________________

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Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

Rate your overall wellness: — 🌟🌟🌟🌟🌟 +
Date of infusion: ________ /________ /________

Mark an X to show the site(s) of this infusion.

Your weight: __________________________ (lb)

Start time: ____________________________(AM/PM)

Dose: _________________________________ (g)

Infusion rate (highest rate tolerated):

________________________________________ mL/hr

Stop time: ________________________________(AM/PM)

Duration of infusion:

________________________________________ hr  __________________________ min

Infusion schedule: __________________________

Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Rotate your site(s) between future infusions.

Questions to discuss with your healthcare team:

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Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

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Expiration date:_____/_____/_______

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Expiration date:_____/_____/_______

Affix the label here or write in:

Lot number:___________________________

Vial size:____________________________

Expiration date:_____/_____/_______

Record any changes in the supplies you used for this infusion:

List medication(s) taken prior to infusion:

List any reactions during and after your infusion:

Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.
### Wellness Tracker for Infusion 47

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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

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Rate your overall wellness: ☹️☹️😊😊😊😊++]

Month: ___________________   Year: ___________________
Infusion 48

Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Your weight: ________________________________ (lb)
Start time: ________________________________(AM/PM)
Dose: _________________________________ (g)
Infusion rate (highest rate tolerated): __________________________ mL/hr
Stop time: ________________________________(AM/PM)
Duration of infusion: __________________________ hr __________________________ min

Rotate your site(s) between future infusions.

Infusion schedule: __________________________

Record any changes in the supplies you used for this infusion:

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List medication(s) taken prior to infusion:

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List any reactions during and after your infusion:

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

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Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

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Vial size: __________________________
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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

**Wellness Tracker for Infusion 48**

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Infusion 49

Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Your weight: ____________________________ (lb)

Start time: ____________________________ (AM/PM)

Dose: ________________________________ (g)

Infusion rate (highest rate tolerated):

______________________________________ mL/hr

Stop time: ____________________________ (AM/PM)

Duration of infusion:

______________________________________ hr ________________________ min

Rotate your site(s) between future infusions.

Infusion schedule: ________________________________

Record any changes in the supplies you used for this infusion:

____________________________________________

____________________________________________

____________________________________________

List medication(s) taken prior to infusion:

____________________________________________

____________________________________________

____________________________________________

List any reactions during and after your infusion:

____________________________________________

____________________________________________

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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

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Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

Affix the label here or write in:

Lot number: ____________________________

Vial size: ____________________________

Expiration date: ____ / ____ / ____

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Vial size: ____________________________

Expiration date: ____ / ____ / ____
Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

**Wellness Tracker for Infusion 49**

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*Month: ___________________   Year: ___________________   Rate your overall wellness: __________*
Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

Infusion schedule: _________________________

Record any changes in the supplies you used for this infusion:

- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________

List medication(s) taken prior to infusion:

- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________

List any reactions during and after your infusion:

- ______________________________________
- ______________________________________
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Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

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Lot number:___________________________
Vial size:____________________________
Expiration date:_____/_____/_______

Affix the label here or write in:

Lot number:___________________________
Vial size:____________________________
Expiration date:_____/_____/_______

Affix the label here or write in:

Lot number:___________________________
Vial size:____________________________
Expiration date:_____/_____/_______

Your weight:_____________________________(lb)

Start time:_____________________________(AM/PM)

Dose:______________________________(g)

Infusion rate (highest rate tolerated):

______________________________________mL/hr

Stop time:_____________________________(AM/PM)

Duration of infusion:

______________________________________hr__________________________________min

Rotate your site(s) between future infusions.

Questions to discuss with your healthcare team:

- ______________________________________
- ______________________________________
- ______________________________________
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</tbody>
</table>

Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
Date of infusion: ________ /________ /________

Mark an X to show the site(s) of this infusion.

Infusion schedule: _________________________

Record any changes in the supplies you used for this infusion:

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

List medication(s) taken prior to infusion:

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

List any reactions during and after your infusion:

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

Affix the label here or write in:
Lot number:_____________________
Vial size:_____________________
Expiration date:_____/_____/_____

Affix the label here or write in:
Lot number:_____________________
Vial size:_____________________
Expiration date:_____/_____/_____

Affix the label here or write in:
Lot number:_____________________
Vial size:_____________________
Expiration date:_____/_____/_____

Affix the label here or write in:
Lot number:_____________________
Vial size:_____________________
Expiration date:_____/_____/_____

Rotate your site(s) between future infusions.

Questions to discuss with your healthcare team:

_______________________________________________________________________

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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

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Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.

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Infusion 52

Date of infusion: ________ / ________ / ________

Mark an X to show the site(s) of this infusion.

- [ ]
- [ ]
- [ ]

Your weight: _________________________________ (lb)

Start time: ________________________________ (AM/PM)

Dose: _________________________________ (g)

Infusion rate (highest rate tolerated):

_____________________________ mL/hr

Stop time: ________________________________ (AM/PM)

Duration of infusion:

_________________________ hr ___________________ min

Rotate your site(s) between future infusions.

Infusion schedule: ________________________________

Record any changes in the supplies you used for this infusion:

________________________________________________

________________________________________________

________________________________________________

List medication(s) taken prior to infusion:

________________________________________________

________________________________________________

________________________________________________

List any reactions during and after your infusion:

________________________________________________

________________________________________________

________________________________________________

Contact your healthcare professional immediately if you experience any infusion-related side effects that persist or worsen.

Questions to discuss with your healthcare team:

________________________________________________

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Remove the peel-off label from each vial (IG only), which has the product lot number, vial size, and expiration date, and affix below. Or write this information from each label in the spaces provided.

Affix the label here or write in:

Lot number: __________________________
Vial size: __________________________
Expiration date: _____/____/____

Affix the label here or write in:

Lot number: __________________________
Vial size: __________________________
Expiration date: _____/____/____

Affix the label here or write in:

Lot number: __________________________
Vial size: __________________________
Expiration date: _____/____/____

Affix the label here or write in:

Lot number: __________________________
Vial size: __________________________
Expiration date: _____/____/____

Affix the label here or write in:

Lot number: __________________________
Vial size: __________________________
Expiration date: _____/____/____
Use this space to track important changes in your overall wellness. Include any notable shifts in lifestyle, activity levels, or treatments and medications, along with the date, and talk to your doctor.
You’ve come a long way! Keep this momentum going.

Use the next pages to document any thoughts or questions that you would like to share with your doctor.

IMPORTANT SAFETY INFORMATION (continued)

What are the possible or reasonably likely side effects of CUVITRU?

CUVITRU can cause serious side effects. If any of the following problems occur after starting CUVITRU, 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.

Please scroll for additional Important Safety Information, click for Information For Patients, including Warning about Blood Clots, and discuss with your HCP.
Communication is one of the most important steps of your treatment.

At this point, you may have noticed what’s working for you, what isn’t, what’s been difficult, or (hopefully) what you’ve been able to master about the infusion process. Jot down any thoughts or questions you want to remember or bring up to your doctor.
What is CUVITRU?
CUVITRU is a ready-to-use liquid medicine that is given under the skin (subcutaneously) to treat primary immunodeficiency (PI) in people 2 years and older.

IMPORTANT SAFETY INFORMATION
What is the most important information I need to know about CUVITRU?
CUVITRU can cause the following serious reactions:
• Severe allergic reactions causing difficulty in breathing or skin rashes
• Decreased kidney function or kidney failure
• Blood clots in the heart, brain, lungs, or elsewhere in the body
• Severe headache, drowsiness, fever, painful eye movements, or nausea and vomiting
• Dark colored urine, swelling, fatigue, or difficulty breathing

Who should not use CUVITRU?
Do not use CUVITRU 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.

What should I avoid while taking CUVITRU?
• CUVITRU can make vaccines (like measles/mumps/rubella or chickenpox vaccines) not work as well for you. Before you get any vaccines, tell your healthcare provider (HCP) that you take CUVITRU.
• Tell your HCP if you are pregnant, or plan to become pregnant, or if you are nursing.

What are the possible or reasonably likely side effects of CUVITRU? (continued)
• Reduced urination, sudden weight gain, or swelling in your legs. These could be signs of a kidney problem.
• Pain, swelling, warmth, redness, or a lump in your legs or arms. These could be signs of a blood clot.
• Brown or red urine, fast heart rate, 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 sign of an infection.

The following one or more possible side effects may occur at the site of infusion. These generally go away within a few hours, and are less likely after the first few infusions.
• Mild or moderate pain • Redness • Itching

What are the possible or reasonably likely side effects of CUVITRU? (continued)
• Headache • Nausea • Fatigue • Diarrhea • Vomiting

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.

For additional safety information, click for Information For Patients and discuss with your HCP.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.
Help is just a tap or call away.
When prescribed a Takeda treatment—whether it’s new to you, you’ve been on treatment, or you’re taking care of someone else—Takeda Patient Support is here to help.

- **A co-pay assistance program**
  Your dedicated specialist will walk you through the insurance process and help you understand what’s covered.

- **Help getting your medicine**
  We can help you receive your treatment by getting your medication when you need it.

- **Nursing support**
  This can be arranged if you have questions about your treatment. Our nurses cannot provide medical advice.

- **Education about your condition**
  We can help you better understand your condition and treatment, and direct you to support resources and education that you can discuss with your healthcare provider.

- **Ongoing support**
  We’re here for you. We’ll share emails and texts with tips and timely info throughout your treatment.

**The Takeda Patient Support Co-Pay Assistance Program may cover**

100% of your out-of-pocket costs if you’re eligible*

**Not enrolled or need assistance?**

You can join Takeda Patient Support in a few simple steps. Visit TakedaPatientSupport.com/enroll or scan this QR code.
Our support specialists are never more than a tap or a call away. Reach us at 1-866-861-1750, Monday through Friday, 8 am to 8 pm ET.

*IMPORTANT NOTICE: The Takeda Patient Support Co-Pay Assistance Program (the Program) is not valid for prescriptions eligible to be reimbursed, in whole or in part, by Medicaid, Medicare (including Medicare Part D), Tricare, Medigap, VA, DoD, or other federal or state programs (including any medical or state prescription drug assistance programs). No claim for reimbursement of the out-of-pocket expense amount covered by the Program shall be submitted to any third party payer, whether public or private. The Program cannot be combined with any other rebate/coupon, free trial, or similar offer. Copayment assistance under the Program is not transferable. The Program only applies in the United States, including Puerto Rico and other U.S. territories, and does not apply where prohibited by law, taxed, or restricted. This does not constitute health insurance. Void where use is prohibited by your insurance provider. If your insurance situation changes you must notify the Program immediately at [1-866-861-1750]. Coverage of certain administration charges will not apply for patients residing in states where it is prohibited by law. Takeda reserves the right to rescind, revoke, or amend the Program at any time without notice.
While your doctor is your best resource, you can always visit CUVITRU.com for helpful info.

Our emails are packed full of good stuff too.
When you sign up for CUVITRU emails, we’ll share helpful, insightful content about CUVITRU, resources, and so much more. (No spam-y emails, only stuff we know patients are interested in.)
Click to sign up.

IMPORTANT SAFETY INFORMATION (continued)
Who should not use CUVITRU?
Do not use CUVITRU 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.

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