

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F Ht: _____ Wt: _____ lbs / kg
 Primary Language: _____ Allergies: _____
 Patient Preferred Location: _____

<ICD 10 CODE REQUIRED>

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

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

Prescribing Information

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

If applicable:

- Previous IG Therapy: _____ Date of Last Dose: _____

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

PRESCRIPTION

HyQvia (Immune Globulin SubQ Infusion)

Subcutaneous Immune Globulin Infusion 10% with Recombinant Human Hyaluronidase.
Subcutaneous Administration Only as tolerated. Hyaluronidase to infuse first at 1-2 mL/minute/site.

SubQ: *subcutaneous administration* to infuse _____ total grams every _____ week(s) for one year

SELECT ONE

- Ramp Up & Maintenance Dose:**
 Patient is new to therapy, follow ramp up scheduling per chart with the indicated dose, then continue to maintenance as indicated
- Maintenance Dose Only:**
 Patient is currently on therapy and will continue as indicated above

TREATMENT INTERVAL	DOSING FREQUENCY Q4 WEEK	DOSING FREQUENCY Q3 WEEK
1st Infusion (week 1)	Grams x 0.25	Grams x 0.33
2nd Infusion (week 2)	Grams x 0.5	Grams x 0.67
3rd Infusion (week 4)	Grams x 0.75	Administer Total Grams
4th Infusion (week 7)	Administer Total Grams	n/a

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

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

Comments: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ **Signature:** _____
 Date: _____ NPI #: _____ Specialty: _____
 Supervising Physician: _____ (If Applicable)
 Address: _____ City: _____ State: _____ Zip: _____
 Contact Name: _____ Phone: _____ Fax: _____ Email: _____