HyQvia Order Form
(Immune Globulin SubQ Infusion)

FAX TO: 972.499.9210

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. _____ Hypogammaglobulinema

☐ 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

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 Loading Dose Only**
Patient is currently on therapy and will continue as indicated above

TREATMENT INTERVAL	DOSING FREQUENCING 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

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

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

Comments:

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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