

Patient Information

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

Diagnosis

ICD 10 Code (PROVIDE COMPLETE CODE)

D80. _____ Hypogammaglobulinemia
 D81. _____ Combined Immunodeficiency
 D82.0 Wiskott-Aldrich Syndrome
 D83. _____ Common Variable Immune Deficiency
 Other ICD 10 Code: _____
 Description _____

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: _____

Medication Order

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

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

Maintenance Dose Only : _____ grams every _____ weeks

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

Comments:

Required Clinical Documentation

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.

Is the patient on any other disease modifying therapy? Yes No
If yes, please note therapy and last dose:

LAB RESULTS: IG Levels and Metabolic panel within 12 months

Medix Infusion will collect all necessary labs if not included in referral documents.

Referring Provider Information

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