

HYQVIA (IMMUNE GLOBULIN INFUSION 10% (HUMAN) WITH RECUMBINANT HUMAN HYLAURONIDASE) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____
 Mobile Number: _____ Patient Weight: _____
 Allergies: _____

DIAGNOSIS (Provider must specify)

Primary Immunodeficiency (PI), ICD 10: _____
 Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), ICD 10: _____
 Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____
 Signature: _____ Date: _____
 Contact Name: _____ Phone: _____ Fax: _____
 Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

Demographics Labs and tests supporting diagnosis Office/progress notes

PRE-MEDICATION (Not typically indicated)

Acetaminophen (Tylenol) 500 mg PO Famotidine 20 mg IV Methylprednisolone (Solu-Medrol) 125 mg IVP
 Benadryl 25mg PO Cetirizine (Zyrtec) 10 mg PO
 Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
HyQvia	<input type="checkbox"/> _____ G/KG <input type="checkbox"/> _____ G	<input type="checkbox"/> Sub Q infusion <input type="checkbox"/> Administer as single day infusion <input type="checkbox"/> Divide dose over _____ days	<input type="checkbox"/> every _____ weeks

New Start Therapy Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS