Local Infusion

MYLOCALINFUSION.COM

HYQVIA ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

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

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

❑ Benadryl 25mg PO

❑ Famotidine 20 mg IV

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

❑ **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:

_____

Total Dose: _____

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

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

FAX NUMBERS:

❐ CT: 203.433.0621
❐ FL: 904.877.9270
❐ MA: 413.296.8482
❐ MD: 240.224.8607
❐ ME: 207.407.7272
❐ NC: 919.984.8698
❐ NH: 603.217.5371
❐ NJ: 201.581.4521
❐ NY: 631.250.6020
❐ OH: 937.871.4594
❐ PA: 610.273.5998
❐ SC: 864.973.6279
❐ VA: 703.202.0499