

HYQVIA ORDER FORM

PATIENT INFORMATION

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

- 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:

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

Total Dose: _____

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

LABS / SPECIAL INSTRUCTIONS

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

FAX NUMBERS:

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