

HyQvia Subcutaneous Infusion Order

Patient Name: _____ DOB: _____ Male Female

Diagnosis (please provide ICD10 code): _____

Other: _____

NKDA _____

Allergies: _____

New Therapy Order _____

Continuation of Therapy _____ Date of last dose: _____

Ordering Provider Name: _____

Provider NPI: _____

Practice Address: _____ Phone: _____ Fax: _____

City: _____ State: _____ Zip Code: _____

Pre-Medication

Acetaminophen _____ mg by PO

Cetirizine _____ mg by PO

Diphenhydramine _____ mg by PO/ IVP

Solu-Medrol _____ mg by PO/ IVP

Solu-Cortef _____ mg by PO/ IVP

Other: _____

Required Documentation:

Patient Demographics

Patient Insurance (med and pharm card copies, front and back)

Progress Notes/Labs supporting diagnosis

Other: _____

HyQvia may be a weight based drug:

Patient Height (cm): _____

HyQvia Medication Order: _____ Patient Weight (kg): _____

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

Please note that doses of less than 0.4g/kg do not need a ramp-up period, provided tolerance by patient.

Infusion Dose Ramp-up starting one week after last IVIG infusion followed by maintenance

▪ Dosing: Full Dose of _____ grams

25% of full dose on weeks 2 and 3, 50% on week 4, 75% on week 6, full dose on week 9.

Other: _____

▪ Maintenance Frequency (Please choose one)

Once every 2 weeks Once every 3 weeks Once every 4 weeks

Other: _____

Primary Immunodeficiency (PI)

Infusion Dose Ramp-up starting one week after last IVIG infusion followed by maintenance

▪ Dosing: Full Dose of _____ grams

25% of full dose on week 1, 50% on week 2, 75% on week 4, full dose on week 7.

Other: _____

▪ Maintenance Frequency (Please choose one)

Once every 3 weeks Once every 4 weeks

Other: _____

Other

Naïve to SCIG treatment or transitioning from SCIG

▪ Dosing: Full Dose of _____ grams (300mg/kg to 600mg/kg recommended)

25% of full dose on week 1, 50% on week 2, 75% on week 4, full dose on week 7.

25% of full dose on weeks 2 and 3, 50% on week 4, 75% on week 6, full dose on week 9.

Other: _____

▪ Maintenance Frequency (Please choose one)

Once every 3 weeks Once every 4 weeks

Other: _____

Maintenance dosing only

▪ Dose of _____ grams

▪ Frequency:

Once every 2 weeks Once every 3 weeks

Once every 4 weeks

Other: _____

Maintenance dosing only

▪ Dose of _____ grams

▪ Frequency:

Once every 3 weeks

Once every 4 weeks

Other: _____

Maintenance dosing only

▪ Dose of _____ grams

▪ Frequency:

Once every 3 weeks Once every 4 weeks

Other: _____

Additional Instructions/Notes:

Ordering Provider:

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____

Locations:

Skokie, IL: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141

Libertyville, IL: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141

Houston, TX: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400