HyQvia Subcutaneous Infusion Order

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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: Phone: Fax:

Practice Address: 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 pharmcard copies, front and back)
□ Progress Notes/Labs supporting diagnosis
□ Other:

HyQvia may be a weight based drug:

Patient Height (cm): Patient Weight (kg):

HyQvia Medication Order:

□ *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: _____

□ Maintenance dosing only
- Dose of _____grams
- Frequency:
  - □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: _____

□ Maintenance dosing only
- Dose of _____grams
- Frequency:
  - □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 3 weeks
  - □ Once every 4 weeks
  - □Other:_____

Additional Instructions/Notes:

OrderingProvider:

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
□ *Orland Park, IL*: 16612 107th Ct, Ste B. P: 847-324-6800. F: 224-251-7141
□ *Houston, TX*: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400