immersiv HEALTH

HYQVIA® FOR CIPD ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ G61.81 Chronic inflammatory demyelinating polyneuritis ☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information ☐ List of Medications ☐ Most recent History & Physical ☐ Recent Labs & IG Levels

MEDICATION ORDER

HyQvia (Sub-Q Immune Globulin 10% with Recombinant Human Hyaluronidase)
Infuse Hyaluronidase subcutaneous first at 1-2 ml/minute/site

Manufacturer Dosing Ramp when Transitioning from IVIG

☐ **INDUCTION:** _____ gm total to infuse via subcutaneous administration for induction step protocol (Ramp Up Period can take 4-9 weeks using chart below.)

Please select frequency for maintenance dose below: (clarification: week 1 = 1 week of of IVIG)

HyQvia Dosing Schedule	☐ Every 4 weeks	☐ Every 3 weeks	☐ Every 2 weeks
Week 1	No Treatment	No Treatment	No Treatment
Week 2	total grams x 0.25	total grams x 0.33	total grams x 0.5
Week 3	total grams x 0.25	total grams x 0.33	total grams x 0.5
Week 4	total grams x 0.5	total grams x 0.67	Full dose and on Q2 week schedule
Week 5	No Treatment	No Treatment	
Week 6	total grams x 0.75	Full dose and on Q3 week schedule	
Week 7	No Treatment		
Week 8	No Treatment		
Week 9	Full dose and on Q4 week schedule		

☐ **MAINTENANCE:** _____ gm every _____ weeks

-OR-

☐ **INDUCTION:** _____ gm total to infuse via subcutaneous administration for induction step per the below Ramp Up:

1st Dose: Administer _____ gm on week _____
2nd Dose: Administer _____ gm on week _____
3rd Dose: Administer _____ gm on week _____
4th Dose: Administer _____ gm on week _____
5th Dose: Administer _____ gm on week _____

☐ **MAINTENANCE:** _____ gm to be infused every _____ weeks

LAB ORDERS LAB: _____ FREQUENCY: _____

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 30 minutes following the first injection.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: (IF APPLICABLE) _____ **CONTACT NAME:** _____

SIGNATURE: (NO STAMPS) _____ _____ **DATE:** _____

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN