

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 polyneuropathy ☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

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


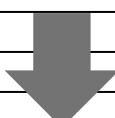
MEDICATION ORDER

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	<input type="checkbox"/> Every 4 weeks	<input type="checkbox"/> Every 3 weeks	<input type="checkbox"/> 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: _____ CONTACT NAME: _____
(IF APPLICABLE)

SIGNATURE: _____ DATE: _____
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN