

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 _____

4th Dose: Administer _____ gm on week _____

2nd Dose: Administer _____ gm on week _____

5th Dose: Administer _____ gm on week _____

3rd 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: _____ DATE: _____
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN