

**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**

- |  |   |
|--|---|
| <input type="checkbox"/> D80.____ Hypogammaglobulinemia        | <input type="checkbox"/> D82.____ Wiskott-Aldrich Syndrome          |
| <input type="checkbox"/> D81.____ Combined immunodeficiency    | <input type="checkbox"/> D83.____ Common Variable Immune Deficiency |
| <input type="checkbox"/> ICD-10 CODE: _____ DESCRIPTION: _____ |   |

**REQUIRED DOCUMENTATION**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Insurance Information | <input type="checkbox"/> List of Medications | <input type="checkbox"/> Most recent History & Physical | <input type="checkbox"/> 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

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- INDUCTION:**
- \_\_\_\_\_ gm total to infuse via subcutaneous administration for induction step protocol

**PLEASE SELECT FREQUENCY BELOW.**

Treatment/Interval	<input type="checkbox"/> Induction for every 3 week frequency	<input type="checkbox"/> Induction for every 4 week frequency
1st infusion/ week 1	total grams x 0.33	total grams x 0.25
2nd infusion/ week 2	total grams x 0.67	total grams x 0.5
3rd infusion/ week 4	Administer total grams	total grams x 0.75
4th infusion/ week 7	N/A	Administer total grams

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- MAINTENANCE:**
- \_\_\_\_\_ gm every \_\_\_\_\_ weeks

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- OTHER:**
- \_\_\_\_\_

**LAB ORDERS**
**LAB:** \_\_\_\_\_ **FREQUENCY:** \_\_\_\_\_

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- 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