

MRN: _____

Phone: 1-800-809-1265 Fax: 1-866-872-8920

DOB: _____

STANDARD HyQvia® PLAN OF TREATMENT

(Re) Certification Period From _____ to _____

NOTE: We require MD office notes and may require a Letter of Medical Necessity (depending on diagnosis), to be able to verify eligibility and payment for this treatment through the patient's insurance plan.

1. Patient Name: _____ Height (inches): _____ Weight (lbs): _____

2. Allergies: _____

3. Diagnosis: * Please complete the 2nd and 3rd digits to complete the ICD-10 code for billing

D80. _____ hypogammaglobulinemia D81. _____ combined immunodeficiency

D82.0 Wiskott-Aldrich syndrome D83. _____ CVID

Other ICD-10 Code: _____ Diagnosis description: _____

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Orders:

Hyaluronidase to infuse first at 1-2 ml/minute/site subcutaneous administration only as tolerated HyQvia® (Subcutaneous Immune Globulin Infusion 10% with Recombinant Human Hyaluronidase)

4. Dose/Frequency: _____ total grams subcutaneous administration via pump to infuse per protocol

Indicate treatment frequency below: (MD must specify frequency and total dose, Pharmacist will calculate weekly doses.)

Treatment Interval		Frequency <input type="checkbox"/> Order every 4 weeks	Frequency <input type="checkbox"/> Order every 3 weeks
1 st Infusion	Week 1	Grams x 0.25	Grams x 0.33
2 nd Infusion	Week 2	Grams x 0.5	Grams x 0.67
3 rd Infusion	Week 4	Grams x 0.75	Administer Total Grams
4 th Infusion	Week 7	Administer Total Grams	n/a
Subsequent doses		<input type="checkbox"/> Administer in the home by patient/caregiver as instructed <input type="checkbox"/> Administer in the ambulatory infusion clinic	

Initial Ramp-up: Administered in infusion clinic where teaching is provided to patient and/or caregiver.

Special orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

Sub-Q IG will not be administered if patient temperature greater than 101.5 orally and MD office will be notified.

5. Physician's Signature: _____ / _____ Date: _____

No Stamp Signatures

(Dispense as written)

(Substitution permitted)

Printed Physician's Name with Credentials: _____ NPI: _____

6. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms and Adverse Drug Reaction Guidelines are available at www.palmettoinfusion.com



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Guidelines for Prescribing HyQvia®

(Required documentation with all initial referrals)

Patient Name: _____

Referral Date: _____

_____ Include signed and completed **Plan of Treatment**. (MD must complete sections 1-6)
 (Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

_____ Include patient demographic information and insurance information. (Copy of insurance cards if available)

_____ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include IG levels, other lab results and/or tests to support diagnosis.**

- HyQvia® is an immune globulin with a Recombinant Human Hyaluronidase indicated for the treatment of Primary Immunodeficiency (PI) in adults. This includes, but is not limited to, common variable immunodeficiency (CVID), X-linked agammaglobulinemia, congenital agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies^{1, 2}.

_____ If patient is currently on IVIG therapy, then please specify therapy and last dose: _____

- For patients previously on another IgG treatment, it is recommended to administer the first dose approximately one week after the last infusion of their previous treatment.

_____ Other as requested: _____

Pre-Screening:

_____ **IG levels**

** Warnings/Precautions: **IgA-deficient patients with anti-IgA antibodies** are at greater risk of severe hypersensitivity and anaphylactic reactions. • **Thrombosis** may occur with immune globulin products, including HYQVIA. Risk factors may include advanced age, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling vascular catheters, hyper viscosity and cardiovascular risk factors. • **Antibodies to PH20** (Recombinant Human Hyaluronidase) can develop. The potential exists for such antibodies to cross-react with endogenous PH20 which is known to be expressed in the adult male testes, epididymis, and sperm. It is unknown whether these antibodies may interfere with fertilization in humans. • **Aseptic Meningitis Syndrome (AMS)** may occur. Discontinue treatment if AMS symptoms appear. • **Acute intravascular hemolysis** may occur. Monitor for clinical signs and symptoms of hemolysis and hemolytic anemia. • Infusion into or around an infected area can spread a localized infection. • **Monitor for pulmonary adverse reactions** (transfusion-related acute lung injury [TRALI]). • **May carry a risk of transmitting infectious agents**, e.g., viruses, the variant Creutzfeldt-Jakob disease (vCJD) agent and, theoretically, the CreutzfeldtJakob disease (CJD) agent. • **Acute renal dysfunction/failure** has been reported in association with Immune Globulin Infusion 10% (Human) administered intravenously. Ensure that patients are not volume depleted prior to the initiation of infusion of HYQVIA. See full prescribing information.

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.