**MRN:**_____

DOB: _____

## STANDARD HyQvia® PLAN OF TREATMENT

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: _____

**4. Orders:**

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

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

**Drug**: **HyQvia® (Subcutaneous Immune Globulin Infusion 10% with Recombinant Human Hyaluronidase)**

- Hyaluronidase to infuse first at 1-2 ml/minute/site ***subcutaneous administration only*** as tolerated

**4. Dose:** □_____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<br>□ Order every 4 weeks | Frequency<br>□ Order every 3 weeks |
|---|---|---|---|
| 1st Infusion | Week 1 | Grams x 0.25 | Grams x 0.33 |
| 2nd Infusion | Week 2 | Grams x 0.5 | Grams x 0.67 |
| 3rd Infusion | Week 4 | Grams x 0.75 | Administer Total Grams |
| 4th Infusion | Week 7 | Administer Total Grams | n/a |
| Subsequent doses | | □ Administer in the home by patient/caregiver as instructed<br>□ Administer in the ambulatory infusion clinic | |

*** DO NOT ADMINISTER IVIG IF PATIENTS TEMPERATURE IS GREATER THAN OR EQUAL TO 101.5 ORALLY AND NOTIFY MD.**

**5. Lab Work:** _____

**6. Physician's Signature**:_____/_____Date: _____

**No Stamp Signatures** (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: _____

*Infusion order forms available at www.palmettoinfusion.com*

Revised 4/20/17

**MRN:** _____

DOB: _____

# Guidelines for Prescribing HyQvia®

**(Required documentation with all initial referrals)**

**Patient Name:** _____ **Referral Date:** _____

☐ Include signed and completed **Plan of Treatment**.

☐ 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 immunodeficiencies1, 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.

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center 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.