Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

HyQvia® Standard Plan of Treatment

PATIENT DEMOGRAPHICS:							
Date of Referral:				Patient's Phone:			
Patient Name:				Address:			
Date of Birth:				City, State, Zip:			
Height in inches:	Weight: LB or KG			Gender:	Allergies:	☐ See list	☐ NDKA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)			
☐	D80. _____ hypogammaglobulinemia		
☐	D81._____ combined immunodeficiency		
☐	D82.0 Wiskott-Aldrich syndrome	☐	D83._____ CVID
☐	_____ - Other:		

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	IG levels		☐ **Continue current order until insurance approved**
6			

MEDICATION ORDERS:

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

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

MEDICATION:

☑ 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)

DOSE/FREQUENCY:

◯ **Induction:** _____gm total to infuse via **subcutaneous administration** for induction per step protocol

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

Treatment/Interval	◯ Induction for every 3 week frequency	◯ 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

◯ Maintenance: _____gm every _____ weeks

SPECIAL ORDERS:

◯ _____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:	ADVERSE REACTION & ANAPHYLAXIS ORDERS:
☑ Start PIV/Access CVC ☑ Flush device per facility standard flushing procedure	Administer acute infusion and anaphylaxis medications per Palmetto Infusion/AccuRX standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:	
PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	

ACCURX
INFUSION CENTER
A PALMETTO INFUSION COMPANY

Checklist for referrals to AccuRX Infusion:

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**

Palmetto Infusion 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. AccuRX Infusion Call Center 888.410.0317. Thank you for the referral.

www.AccuRXInfusion.com

02/08/2023