Palmetto INFUSION®

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

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:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion 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	