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 ☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	D80.____ - Hypogammaglobulinemia	☐	D83.____ - Common variable immunodeficiency
☐	D81.____ - Combined immunodeficiency	☐	D82.____ Wiskott-Aldrich syndrome
☐	_____-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**

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:

☑ 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

DOSE/FREQUENCY:

☐ Induction: _____gm total to infuse via subcutaneous administration for induction step protocol

Treatment/Interval	☐ Induction for every 3 week frequency	☐ Induction for every 4 weeks 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

OR

☐ Induction: ___gm total to infuse vial subcutaneous administration for induction step per the below Ramp up:

1st Dose - Administer ____ grams on week_____

2nd Dose - Administer____ grams on week_____

3rd Dose - Administer ____ grams on week_____

4th Dose - Administer ____ grams on week_____

5th Dose - Administer ____ grams on week_____

☐ Maintenance Dose: ____grams to be infused every ____weeks

☑ Refills x 12 months unless noted otherwise here:

NURSING ORDERS:

☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated.

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	