

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Patient preferred clinic:	<input type="checkbox"/> Order Renewal

HyQvia® Standard Plan of Treatment for CIDP

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:
	<input type="checkbox"/> See list <input type="checkbox"/> NKDA

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

G61.81-Chronic inflammatory demyelinating polyneuritis	Other:
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REQUESTED DOCUMENTATION:

1 Insurance information	IF NO:	IF YES:
2 Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3 Full medication list	REQUIRED	NEXT INFUSION DATE:
4 Tried and failed therapies	WASHOUT FROM	IF ORDER CHANGE:
5 IG levels	PREVIOUS THERAPY:	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:

Manufacturer Dosing Ramp when Transitioning from IVIG

Induction: ___gm total to infuse via subcutaneous administration for induction step protocol (Ramp Up Period can take 4-9 weeks using chart below)

Please select frequency for maintenance dose below: (clarification: week 1=1 week off of IVIG)

Hyqvia Dosing Schedule	Every 4 weeks	Every 3 weeks	Every 2 weeks
Week 1	No Treatment		
Week 2	total grams x 0.25	total grams x 0.33	total grams x 0.5
Week 3	total grams x 0.25	total grams x 0.33	total grams x 0.5
Week 4	total grams x 0.5	total grams x 0.67	Full dose and on Q2 week schedule
Week 5	No Treatment	No Treatment	↓
Week 6	total grams x 0.75	Full dose and on Q3 week schedule	
Week 7	No Treatment	↓	↓
Week 8	No Treatment		
Week 9	Full dose and on Q4 week schedule		

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 _____ | 4th Dose - Administer ___ grams on week _____ |
| 2nd Dose - Administer ___ grams on week _____ | 5th Dose - Administer ___ grams on week _____ |
| 3rd 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