

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 2<sup>ND</sup> AND 3<sup>RD</sup> 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	<b>IF ORDER CHANGE:</b>
5	IG levels	PREVIOUS THERAPY:	
			<b>Continue current order until insurance approved</b>

### 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



## Checklist for referrals to Palmetto Infusion: Fax referral to 1.800.521.9640

- 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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

[www.PalmettoInfusion.com](http://www.PalmettoInfusion.com)