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

HyQvia® Standard Plan of Treatment

Rev 4.28.25

PATIENT DEMOGRAPHICS:

Patient Name:							
Patient's Phone:		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:	ADVERSE REACTION & ANAPHYLAXIS ORDERS:
☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated.	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website.

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	

Palmetto INFUSION

Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- ☐ **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