Hyqvia Infusion Order

InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: ___/___/___ Treatment Location: _____

***Please fax a copy of the following patient information:**

- ☐ Demographics
- ☐ H & P Relevant to the Diagnosis
- ☐ Current Medications
- ☐ Current CBC & CMP
- ☐ IgG Labs or Antibody Titers
- ☐ Insurance Information

PATIENT INFORMATION

Patient Name: _____

DOB: ___/___/___

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ___/___/___

Phone: (___) ___ - ____ Fax: (___) ___ - ____

Office Address: _____

Contact Person: _____

PRE-MEDICATIONS: (USUALLY NOT INDICATED)

Acetaminophen:	☐ PO		☐ 650mg		☐ Pre-med	☐ PRN
Diphenhydramine:	☐ PO	☐ IV	☐ 25mg	☐ 50mg	☐ Pre-med	☐ PRN
Zyrtec:	☐ PO		☐ 10mg			

HYQVIA DOSAGE

Date of Last Treatment, If Continuation:

10% Immune Globulin Solution SQ

Patient Weight: _____ kg x (300mg - 600mg) _____ mg/kg ÷ 1000 = _____ grams

Frequency: ☐ 3 weeks ☐ 4 weeks Duration: _____

Start Date of Infusion: ___/___/___

Revised 10/21/21

HyQvia
[Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase]
PRESCRIPTION REFERRAL FORM

Infusion for Health
77 Rolling Oaks Dr. suite 201
Thousand Oaks, CA 91361
P: 805-719-3700 F: 805-852-2636

PREVENT SUBSTITUTIONS
Write "Dispense as Written"

Fax completed form to (855) 217-1619

HOW CAN MYIGSOURCE HELP YOU? ☐ Register Only ☐ New Patient ☐ Continuing Patient ☐ Conversion Patient ☐ Co-Pay Card ☐ Smart Start ☐ BV Only

SECTION A PATIENT INFORMATION (REQUIRED)

PATIENT NAME: DATE OF BIRTH: SEX (M/F):

ADDRESS: CITY: STATE: ZIP:

TELEPHONE: E-MAIL:

PARENT/GUARDIAN NAME: DIAGNOSIS CODES: *LIST PRINCIPAL DIAGNOSIS FIRST*

REQUIRED IF PATIENT IS YOUNGER THAN 18 YEARS

☐ ENGLISH IS 2ND LANGUAGE PRIMARY LANGUAGE: CURRENT TREATMENT:

SECTION B INSURANCE INFORMATION

If benefits processing is requested, please provide a copy (front & back) of insurance card or of any medical and/or prescription cards.

SECTION C PRESCRIBER PREFERENCE

PREFERRED SITE OF CARE (MARK ONE):

☒ Infusion suite ☐ Hospital outpatient ☐ Prescriber's office ☐ Home infusion ☐ Begin treatment in clinical setting, then transition to homecare

PREFERRED INFUSION PROVIDERS: Infusion for Health - Fax: 805-852-2636

WOULD YOU LIKE THE INFUSION PROVIDER TO CONTACT YOU REGARDING NURSING NOTES/PHARMACY PROGRESS REPORTS ON THE STATUS OF THE PATIENT? _____YES _____NO

SECTION D PRESCRIPTION & MEDICAL ORDERS

☐ **Patient switching from Immune Globulin Intravenous (Human) [IGIV] treatment: Administer HYQVIA at the same dose and frequency as the previous intravenous treatment, after the initial ramp-up.[1]**

☐ **Patient naïve to IgG treatment or switching from Immune Globulin Subcutaneous (Human) [IGSC]: Administer HYQVIA at 300 to 600 mg/kg at 3 to 4 week intervals, after the initial ramp-up.[1]**

Patient weight: _____ kg X Ordered Dose: _____ mg/kg ÷ 1000 = Total Grams: _____ grams X 10 = Volume: _____ mL

☐ Pharmacy to calculate infusion parameters per package insert (PI) recommendation

_____ Refills (as allowed by state or payer requirement)

☐ Prescriber alternate instruction: _____

Number of infusion sites : ☐ One (1) infusion site ☐ One (1) – Two (2) infusion site(s)

Infusion site: ☐ Abdomen ☐ Thigh ☐ Other: _____

High flow 24 G needle length : ☐ 6 mm ☐ 9 mm ☐ 12 mm ☐ 14 mm

☐ Peristaltic pump ☐ Syringe driver pump ☐ Provide pump and related infusion supplies

Additional services

☐ Provide needles, syringes, VAD supplies & other ancillary supplies needed for infusion
☐ DME—Infusion pump with supplies
☐ Pharmacy to provide anaphylactic kit: _____

Treatment interval and ramp up schedule[1]

For patients previously on another IgG treatment, the first dose should be given approximately one week after the last infusion of their previous treatment.

Treatment Interval ☐ 4 weeks ☐ 3 weeks

1st infusion	1st week	Grams X 0.25	Grams X 0.33
2nd infusion	2nd week	Grams X 0.50	Grams X 0.67
3rd infusion	4th week	Grams X 0.75	Total Grams
4th infusion	7th week	Total Grams	n/a

Infusion parameters for Recombinant Human Hyaluronidase (HY) and Immune Globulin Infusion 10% (IG)[1]

Rate of administration for HY: ☐ 1 - 2 mL/min/site(s), or as tolerated

Rate of administration for IG:	☐ Subjects <40 kg (<88 lbs)		☐ Subjects ≥40 kg (≥88 lbs)	
	First 2 Infusions	Subsequent 2 or 3 Infusions	First 2 Infusions	Subsequent 2 or 3 Infusions
Intervals (minutes)	Rate per site (mL/hour)	Rate per site (mL/hour)	Rate per site (mL/hour)	Rate per site (mL/hour)
5 - 15	5	10	10	10
5 - 15	10	20	30	30
5 - 15	20	40	60	120
5 - 15	40	80	120	240
Remainder of infusion	80	160	240	300

SECTION E PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME: OFFICE CONTACT:

ADDRESS: CITY: STATE: ZIP:

TELEPHONE: FAX: E-MAIL:

FACILITY OR PRESCRIBER TAX ID #: DEA #: NPI #:

PLEASE NOTE: TWO SIGNATURES ARE REQUIRED

- I verify that the patient has been informed of the diagnosis listed in Section A of this form.
- I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed HYQVIA based on my professional judgment of medical necessity. I authorize Baxter Healthcare Corporation and its affiliated companies, agents and representatives, and contracted third parties ("Baxter and Baxter Parties") to contact my patient regarding Baxter programs, and to forward this prescription electronically, by facsimile, or by mail to the dispensing pharmacy selected above (if applicable). I authorize the dispensing pharmacy to share information with Baxter and Baxter Parties about this patient. I also authorize Baxter and Baxter Parties to perform any steps necessary to obtain reimbursement for HYQVIA, including but not limited to insurance verification and case assessment. I understand that additional information may be required, and I agree to provide it as needed for the purposes of reimbursement.

☐ **DISPENSE AS WRITTEN** Exact terminology may be based on state regulations. Please provide state-specific prescription language here: _____

PRESCRIBER SIGNATURE (REQUIRED): DATE: EN (FOR INTERNAL PURPOSES ONLY):

PRESCRIBER AUTHORIZATION (REQUIRED)

By signing below, I certify that I have received the necessary written authorization from the patient to release the medical and/or patient information referenced on this form relating to the above-referenced patient to Baxter Healthcare Corporation and its affiliated companies, agents and representatives, and contracted third parties for all of the purposes I authorize above, including seeking reimbursement support, verifying insurance coverage and/or the evaluation of the patient's eligibility for alternate sources of funding, contacting the patient for the purpose of enrollment in Baxter patient support services, and to facilitate materials fulfillment and product fulfillment via dispensing pharmacies.

PRESCRIBER SIGNATURE (REQUIRED): DATE:

For more information, call MyIgSource at 855-250-5111 or visit www.HYQVIA.com

Please see the Indication and Detailed Important Risk Information on reverse side of this form and the accompanying full Prescribing Information, including boxed warning.

Baxter