HyQvia SubQ (Immune Globulin 10% w/ hyaluranidase)

Provider Order Form *rev. 1/2/2025*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

Referral Status: ☑ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

☐ D80.0 Hereditary hypogammaglobulinemia
☐ D81.9 Combined immunodeficiency, unspecified
☐ D82.0 Wiskott-Aldrich syndrome
☐ D83.0 Common variable immunodeficiency with predominant abnormalities of B-cell numbers and function
☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☐ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO
☐ Cetirizine (Zyrtec) 10mgPO
☐ Loratadine (Claritin) 10mgPO
☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
☐ Other: _____ Dose: _____ Route: _____

Lab Orders

Required: Serum Creatinine, IG levels
**Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.
☐ Other: _____

HyQvia SC: (Select one):
Subcutaneous Immune Globulin Infusion 10% with Recombinant Human Hyaluronidase
Infuse _____ gm (target dose*) subcutaneously every _____ weeks after the initial ramp up per package insert.

☐ Ramp up & Maintenance Dose: Patient is new to therapy, follow ramp up scheduling per chart with the indicated dose, then continue to maintenance as indicated.
☐ Maintenance Loading Dose only: Patient is currently on therapy and will continue as indicated above.

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

☐ **Refills:** ☐ zero ☐ 6 months ☐ 12 months
☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

Special Instructions:_____

Treatment Interval	Dosing Frequency Q4 Week	Dosing Frequency Q3 Week
1st Infusion (week 1)	Grams x 0.25	Grams x 0.33
2nd Infusion (week 2)	Grams x 0.5	Grams x 0.67
3rd Infusion (week 4)	Grams x 0.75	Administer Total Grams
4th Infusion (week 7)	Administer Total Grams	N/A

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

_____ _____ _____
Provider Name (Print) *Provider Signature* *Date*

E: Referrals@americaninfusioncare.com
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McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454