

HYQVIA RX ENROLLMENT FORM

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Gender: _____
 Home Phone: _____ Cell Phone: _____ Email: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Emergency Contact: _____ Emergency Phone: _____

CLINICAL INFORMATION

Diagnosis ICD-10 Code: _____
 Patient Weight: _____ kg lbs
 Patient Height: _____ cm in
 Allergies: _____
 Has patient previously received IG? Yes No
 Pharmacy to coordinate home health nursing visit and/or nursing training
 Patient already trained on HyQvia Subcutaneous Infusion and patient trained with the following infusion pump: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
 DEA #: _____ NPI #: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 Contact Person: _____

PRESCRIPTION INFORMATION

Dose and Directions
 Infuse _____ GRAMS SC every _____ week(s).
 Calculate dose:
 Infuse _____ kg x _____ mg/kg divided by 1000 =
 Total: _____ GRAMS SC every _____ week(s).
 Other _____
 * Pharmacy to round to the nearest vial size

Administration Rate *per package insert recommendation
 1. Recombinant Human Hyaluronidase SubQ
 Push at 1-2 mL/min/site as tolerated
 2. Adult HyQvia 10% Infusion Rate
 per manufacturer's guidelines and patient tolerance

Infuse via: One infusion site Two infusion sites Three infusion sites
Infuse in: Abdomen Thigh Other _____
Use SQ Needle: 6mm 9mm 12mm 14mm
 * Number of infusion sites, location of site, length of needle, and infusion rates may be adjusted/selected per pharmacist discretion using manufacturer's product labeling.

Ramp-Up Requirement:
 Patient already established on HyQvia, no ramp-up needed
 Patient will be needing ramp-up dosing, pharmacist to determine ramp-up schedule following the guidelines below:

Initial Treatment Interval and Ramp-Up Schedule for PI:
 For patient previously on another IgG treatment, the first dose should be given approximately 1 week after the last infusion of their previous treatment.

Week	Infusion	Every 4 weeks	Every 3 weeks	Calculated Dose
1	1st	25% of Full Dose	33% of Full Dose	
2	2nd	50% of Full Dose	67% of Full Dose	
4	3rd	75% of Full Dose	Full Dose	
7	4th	Full Dose		

Initial Treatment Interval and Ramp-Up Schedule for CIDP if switching from IVIG:
 Doses less than or equal to 0.4 g/kg can be administered without ramp-up. Patient must be on stable doses of IVIG for 12 weeks before switching to HyQvia.

Week	Infusions	Dose	Calculated Dose
Switch from IVIG			
1	No Infusion		
2	1st Dose	Total grams x 0.25	
3	2nd Dose	Total grams x 0.25	
4	3rd Dose	Total grams x 0.50	
6	4th Dose	Total grams x 0.75	
9	5th Dose	Full Dose	

REQUIRED FOR HOME INFUSION RX to include diluents, needles, syringes, ancillary supplies, home medical equipment to administer infusion.

Pre and Post Medications Please strikethrough if not required	To be given by mouth 30 minutes prior to infusion. May repeat every 4-6 hours as needed.				*For subcutaneous patients only* if requested by patient/nurse. Lidocaine 2.5%/Prilocaine 2.5% topical (may dispense Lidocaine 4%) to injection site(s) at least 1 hour prior to needle insertion.
		Adult	6-12 years old	2-5 years old	
	Diphenhydramine	25mg-50mg max 100mg/day	12.5mg - 25mg	6.25mg - 12.5mg	
	Acetaminophen	325mg-650mg max 3000mg/day	10-15mg/kg		

Anaphylaxis Protocol
To be given intramuscularly PRN severe allergic reaction. Call 911. May repeat x 1.
 • Epinephrine 0.3mg (≥30kg/66lbs) • Epinephrine 0.15mg (15kg to <30kg /33lbs to <66lbs)

Quantity and Refills
 Dispense 1-month supply with 1-year refill unless indicated below.
 Dispense 3-month supply with 1-year refill Other _____

Additional Orders

PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

<input type="checkbox"/> May Substitute/Product Selection Permitted/Substitution Permissible	<input type="checkbox"/> Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute
Prescriber Signature _____	Prescriber Signature _____
Date _____	Date _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" NY & Iowa providers, please submit electronic prescription.

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