EPS Rx — A CarePartners Pharmacy Company | CarePartners Specialty Infusion

Phone : 844-800-5377 Fax : 214-782-9155

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).

☐ Calulate 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.

	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	

***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.

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.

☐ May Substitute/Product Selection Permitted/Substitution Permissible

Prescriber Signature ______ **Date** ______

☐ Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute

Prescriber Signature ______ **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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