Phone: **1-877-342-9352**
Fax: 1-877-542-9352

HyQvia Referral Form

IG specialist information

Name: _____

Phone: _____

Patient information

Patient name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

DOB: _____ SSN: _____

Gender: ☐ Male ☐ Female

Emergency contact: _____

Phone: _____ Relationship: _____

Insurance information

Primary insurance: _____

Phone: _____ Subscriber: _____

Policy #: _____ Group: _____

Prescription drug card: _____

Policy #: _____ Phone: _____

Secondary insurance: _____

Phone: _____ Subscriber: _____

Policy #: _____ Group: _____

Primary diagnosis

☐ Common variable immunodeficiency
☐ Common hypogammaglobulinemia
☐ Immunodeficiency with increased IgM
☐ Combined immunity deficiency
☐ Wiskott-Aldrich syndrome
☐ Other: _____

Medical assessment

Height: _____ Weight: _____ ☐ lbs ☐ kg

Advanced directives? ☐ Yes ☐ No

Kidney or heart disease? ☐

☐ Diabetic What is the current A1c? _____ mg/dL

Ambulatory? ☐ Yes ☐ No

Homebound? ☐ Yes ☐ No

Is patient currently on any medications? ☐ Yes ☐ No

List: _____

_____

Allergies: _____

_____

Prescription and orders for patients already receiving IV immune globulin therapy:

Current product? _____

Dose: _____ grams every _____ weeks for _____ cycles

Date of last infusion: _____

☐ Administer HyQvia at the same dose and frequency as current product after the initial ramp-up is complete.

☐ First dose to begin one week after the last infusion of current treatment.

Prescription and orders for patients naive to IgG or switching from a subcutaneous product:

☐ Administer HyQvia _____ grams, every _____ weeks for _____ cycles

(Please enter the final dose and frequency the patient is to receive after ramp-up is complete).

Ramping schedule:

☑ Pharmacist to calculate infusion parameters per package insert for initial ramp-up

Other orders

Pre-medication: _____

☐ Acetaminophen 325mg; 1-2 tabs every 4-6 hours as needed, not to exceed 8 tabs per day.

☐ Diphenhydramine 25-50 mg orally before infusion as needed.

☐ Other: _____

Adverse/anaphylactic reactions per BriovaRx Infusion Services protocol:

✓ Mild reaction give Diphenhydramine 50mg (two tabs), slow infusion. If needed give two additional tabs (50mg).

✓ Moderate reaction give 50mg Diphenhydramine (two tabs) and stop infusion.

✓ Severe reaction with breathing problem give 50mg IV Diphenhydramine; EpiPen; 500ml Nacl 0.9% fluid and call 911.

Nursing:

☑ As required for SQ administration and teaching of the infusion in home

Labs: _____

Physician information

Physician: _____

Practice: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

NPI: _____ Contact: _____

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy.

Physician signature: _____ Date: _____
(Substitution permissible, signature required)

Physician signature: _____ Date: _____
(Substitution permissible, signature required)