INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

HyQvia *immune globulin infusion 10% with recombinant human hyaluronidase*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Primary Immunodeficiency (PI), ICD 10: _____

☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), ICD 10: _____

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

☐ Ramp up & maintenance dose — patient is new to therapy; follow ramp-up scheduling per chart with the indicated dose, then continue to maintenance every _____ weeks

☐ Maintenance loading dose only — patient is currently on therapy and will continue as indicated every _____ weeks

Total dose: _____

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

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____