HyQvia Infusion Order

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

☐ G61.81 Chronic Inflammatory Demyelinating Polyneuritis (CIDP)

☐ Other: _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ICD 10: _____

ALSO INCLUDE...

◯ Clinical/ Progress Notes

◯ Demographics Sheet

◯ Current Medications

◯ Labs

Sub Q IVIG ORDER

Medication: ☐ HyQvia

Patients Weight: _____ **Dose:** _____ **Frequency:** _____

◯ Round Dose Up ◯ Round Dose Down

Please Include:

Date of last IVIG Infusion: _____

☐ Pre-meds _____

☐ Epinephrine 0.3 as needed for severe allergic reactions.

☐ Pumps, DME, ancillary supplies necessary for drug admin

☐ Home care nursing to train patient on how to administer on their own.

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____