

Updated Order    Order Renewal

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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

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Patient Address: \_\_\_\_\_ Patient Email: \_\_\_\_\_

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Allergies: \_\_\_\_\_  NKDA   Weight (lbs/kg): \_\_\_\_\_ Height (in/cm): \_\_\_\_\_

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Sex:  M /  F   Date of Last Infusion: \_\_\_\_\_ Next Due Date: \_\_\_\_\_ Preferred Location: \_\_\_\_\_

**DIAGNOSIS (Please provide ICD-10 code in space provided)**

Primary Immunodeficiency: \_\_\_\_\_ Chronic Inflammatory Demyelinating Polyneuropathy: \_\_\_\_\_

Other: \_\_\_\_\_

**THERAPY ADMINISTRATION (Select one)**

**Chronic Inflammatory Demyelinating Polyneuropathy**

- Doses less than or equal to 0.4 g/kg can be administered without ramp-up
- Patients must be on stable doses of IVIG for 12 weeks before switching to HYQVIA

Patients transitioning from IVIG tx, administer HyQvia at the same dose and frequency as the previous IV tx, after the initial dose ramp-up as indicated per the manufacturer.

Dose: \_\_\_\_\_ GM subcutaneously  
 Frequency:  every 2 weeks /  every 3 weeks  every 4 weeks

**Primary Immunodeficiency**

Patients transitioning from IVIG tx, administer HyQvia at the same dose and frequency as the previous IV tx, after the initial dose ramp-up as indicated per the manufacturer.

Dose: \_\_\_\_\_ GM subcutaneously  
 Frequency:  every 3 weeks  every 4 weeks

New to SCIG treatment or transitioning from SCIG, administer HyQvia at 300mg/kg to 600mg/kg at 3- or 4-week intervals, after the initial ramp up as indicated by the manufacturer.

Dose: \_\_\_\_\_ GM subcutaneously  
 Frequency:  every 3 weeks /  every 4 weeks.

**ADDITIONAL ORDERS**

**LABORATORY ORDERS**

- CBC w/ diff                       at each dose                       every: \_\_\_\_\_
- CMP                                       at each dose                       every: \_\_\_\_\_
- Other: \_\_\_\_\_

**PRE-MEDICATION ORDERS**

- Tylenol  500mg /  650mg PO
- Loratadine 10mg PO
- Pepcid 20mg  PO /  IVP
- Benadryl  25mg /  50mg    PO /  IVP
- Solumedrol  40mg /  125mg IVP
- Other: \_\_\_\_\_

**NURSING**

- Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

Ramp Up Schedule			
CIDP ramp up	PI ramp up if switching from IVIG	Ramp up if switching from SCIG or new to SCIG	
Wk 1-no tx	Wk 1 total gmX0.25	3 weeks	4 weeks
Wk 2&3 total gm x0.25	Wk 2 total gmX0.5	Wk 1 total gmX0.33	Wk1 total gmX0.25
Wk 4 total gm X0.50	Wk 4 total gmX0.75	Wk 2 total gmX0.67	Wk2 total gmX0.5
Wk 6 total gm x0.75	Wk 7 total dose	Wk 4 total dose	Wk 4 total gmX0.75
Wk 9 total dose			Wk 7 total dose

**PROVIDER INFORMATION**

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Preferred Contact Name: \_\_\_\_\_ Preferred Contact Email: \_\_\_\_\_

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Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

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Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)**

- Required Documentation:** Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications. EMG (dx CIDP)
- Required Labs:** Immunoglobulin levels, Renal function, CRP/ESR, ANA,

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**Provider Name (print)** \_\_\_\_\_ **Provider Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

**Disclaimer:** By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.

