



Please Fax Completed Form To: **888-340-3699**

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

Please Send a Copy of The Patient's Up-to-Date Clinical Notes

PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____	Prescriber Name: _____ State License: _____ NPI #: _____ Tax ID: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)	
Primary Insurance: _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____	Secondary Insurance (If Applicable): _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____

CLINICAL INFORMATION	
ICD-10 Code(s) & Description: _____	
<b>PI: Attach Labs</b> IgA Level (mg/dL): _____ Pre-Titer Level (mcg/mL): _____ IgG Level (mg/dL): _____ IgM Level (mg/Dl): _____ Post Titer Level mcg/mL: _____	<b>CIDP: Attach reports</b> EMG/NCS/Nerve Ultrasound (m/sec): _____ NF155 Levels: _____ CNTN1 Levels: _____ MRI Results: _____

ORDERS
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Indication
<input type="checkbox"/> HyQvia® [Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase] Solution.	<input type="checkbox"/> For PI: <input type="checkbox"/> If switching from IVIG (human) treatment, administer HYQVIA at the same dose and frequency as the previous IV treatment, after the initial dose ramp-up <input type="checkbox"/> If naive to SCIG (human) treatment or switching from SCIG, administer HYQVIA at 300 mg/kg to 600 mg/kg at 3-week or 4-week intervals, after the initial ramp-up <input type="checkbox"/> For CIDP: <input type="checkbox"/> If switching from IVIG (human) treatment, administer HYQVIA at the same dose and frequency as the previous IV treatment, after the initial dose ramp-up

Dose/Frequency	
<input type="checkbox"/> <b>Infusion provider to calculate ramp-up dose per the ramp-up</b> Patient weight (kg): _____ x dose (mg/kg): _____ Frequency: <input type="checkbox"/> every 2 weeks <input type="checkbox"/> every 3 weeks <input type="checkbox"/> every 4 weeks Refills: _____ Number of infusion site(s): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 Infusion site(s): <input type="checkbox"/> Middle to upper abdomen <input type="checkbox"/> Thigh(s) High-flow 24G needle length (check one): <input type="checkbox"/> 6mm <input type="checkbox"/> 9mm <input type="checkbox"/> 12mm <input type="checkbox"/> 14mm	

Pre-Medication	Dose/Strength	Directions
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> 500mg	<input type="checkbox"/> Take 1-2 tablets PO prior to infusion or post-infusion as directed
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	<input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed OR
<input type="checkbox"/> _____	_____	

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INFUSIONREACTION ORDERS

Mild reaction protocol:
Moderate reaction protocol:
Severe reaction protocol: (Call 911 if initiated):

FLUSHING & LOCKING ORDERS

Flushing Protocol (>66lbs/33kg)
Locking Protocol (>66lbs/33kg)

\*\* May substitute Dextrose 5% in Water, or alternative, for 0.9& Sodium Chloride, when indicated due to incompatibility with medications bring infused

SIGNATURE

We hereby authorize Infuse IQ to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.
X \_\_\_\_\_ Date: \_\_\_\_\_
Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.