## HyQvia (Immune Globulin 10% w/ Hyaluronidase) Subcutaneous Prescriber Order Form – Adult & Pediatrics

Patient Name:					DOB:	
Address:						
Phone:		Height:	Height:		Weight:	
Clinical Information						
Primary Diagnosis Description: ICD-10 Code:						
HyQvia:						
Infuse gm (target dose*) subcutaneously every weeks after the initial ramp up per package insert.						
☐ HyQvia-naïve; initial ramp up as below. ☐ Prior HyQvia target dose reached; no ramp up required.						
	Infusion Number	Week	Every	Week Interval	Dose	
	☐ 1 <sup>st</sup> infusion	Week	% o	f target dose*	grams	-
	☐ 2 <sup>nd</sup> infusion	Week	% o	f target dose*	grams	
	☐ 3 <sup>rd</sup> infusion	Week	% of target dose*		grams	
	☐ 4 <sup>th</sup> infusion	Week	% o	f target dose*	grams	=
	☐ 5 <sup>th</sup> infusion	Week	% o	f target dose*	grams	]
<ul> <li>For each full or partial vial of Immune Globulin (IG) 10%, administer the entire contents of accompanying Hyaluronidase. Administer Hyaluronidase at a rate of 1 - 2 ml/min via subcutaneous push. Immediately thereafter administer Immune Globulin (IG) 10%.</li> <li>Round dose to nearest vial size. Immune Globulin (IG) 10% manufactured as 100 mg/ml solution in sizes of 2.5 gm/25 ml, 5 gm/50 ml, 10 gm/100 ml, 20 gm/200 ml &amp; 30 gm/300 ml</li> <li>Target dose may be administered over multiple days in divided doses with 48-72 hours between doses based on maximum daily dose or infusion tolerability as assessed by pharmacist. ☐ Decline</li> <li>Pharmacist/Nursing to calculate infusion parameters, number of sites, and administration location per package insert and adjust based on patient tolerance. May infuse +/- 4 days to allow for patient scheduling.</li> <li>Ancillary Orders:         <ul> <li>Acetaminophen mg PO 30 min before infusion. Patient may use own supply or patient may decline.</li> <li>Diphenhydramine mg PO 30 min before infusion. Patient may use own supply or patient may decline.</li> <li>Lidocaine 2.5%/prilocaine 2.5% cream 30 gm tube: Apply to SubQ site(s) during access prn.</li> <li>Other:</li> <li>Anaphylaxis Orders: Epinephrine Auto-Injector 0.3 mg (≥ 30 kg) or 0.15 mg (15 to 30 kg) 2-Pack – Inject 1 dose IM x 1 PRN anaphylactic reaction, repeat x1 PRN.</li> </ul> </li> </ul>						
<ul> <li>Skilled nurse to assess and teach self-administration of SUBQ medication where appropriate. Nurse will provide ongoing support, including administration of medication, PRN.</li> <li>Refill above ancillary orders as directed x 1 year.</li> </ul>						
I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.						
Prescriber Signature: Dispense as written Date:						
Prescriber Name:				Specialty:		
Address:				Office Contact:		
City: State: Zip:				Hospital/Clinic:		
Phone: Fax:						

Fax completed form, insurance information, and clinical documentation to:

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