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

| **Patient Name:** | | **DOB:** |
|---|---|---|
| **Address:** | | |
| **Phone:** | **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 |
|---|---|---|---|
| ☐ 1st infusion | Week ____ | ____% of target dose* | ____ grams |
| ☐ 2nd infusion | Week ____ | ____% of target dose* | ____ grams |
| ☐ 3rd infusion | Week ____ | ____% of target dose* | ____ grams |
| ☐ 4th infusion | Week ____ | ____% of target dose* | ____ grams |
| ☐ 5th infusion | Week ____ | ____% of target dose* | ____ grams |

- Dispense: Sizes & quantities sufficient. Ramp doses: x 1 refill each. HyQvia target dose refill as directed x 1 year.
- 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%.
- 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 & 30 gm/300 ml
- 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
- 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.

## Ancillary Orders:

☐ Acetaminophen _____ mg PO 30 min before infusion. Patient may use own supply or patient may decline.

☐ Diphenhydramine _____ mg PO 30 min before infusion. Patient may use own supply or patient may decline.

☐ Lidocaine 2.5%/prilocaine 2.5% cream 30 gm tube: Apply to SubQ site(s) during access prn.

☐ Other:_____

- 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.
- Skilled nurse to assess and teach self-administration of SUBQ medication where appropriate. Nurse will provide ongoing support, including administration of medication, PRN.
- Refill above ancillary orders as directed x 1 year.

*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:**



 