HyQvia (Immune Globulin 10% w/ Hyaluronidase)

Subcutaneous Prescriber Order Form – Adult & Pediatrics

Patient Name:		**DOB:**	**Gender:**
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.

If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

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: 713-983-4647

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