



option care health®

Dear Provider,

Specialty therapies can be complex, and complete information is essential to help ensure timely access to care.

The following prescriber order form is designed to capture the necessary clinical and patient information the dispensing pharmacy requires to begin the applicable prescribed therapy.

If your patient has elected to use Option Care Health, please fax completed form and required clinical documentation to **713-983-4647**.

Sincerely,  
Option Care Health

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

<b>Patient Name:</b> _____	<b>DOB:</b> _____	<b>Gender:</b> _____
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**Address:** \_\_\_\_\_

<b>Phone:</b> _____	<b>Height:</b> _____	<b>Weight:</b> _____
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**Clinical Information**

<b>Primary Diagnosis Description:</b> _____	<b>ICD-10 Code:</b> _____
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**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
<input type="checkbox"/> 1 <sup>st</sup> infusion	Week _____	_____% of target dose*	_____ grams
<input type="checkbox"/> 2 <sup>nd</sup> infusion	Week _____	_____% of target dose*	_____ grams
<input type="checkbox"/> 3 <sup>rd</sup> infusion	Week _____	_____% of target dose*	_____ grams
<input type="checkbox"/> 4 <sup>th</sup> infusion	Week _____	_____% of target dose*	_____ grams
<input type="checkbox"/> 5 <sup>th</sup> 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 pm.
- 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: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	Specialty: _____ Office Contact: _____ Hospital/Clinic: _____
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