HyQvia (Immune Globulin Infusion 10%(Human) with Recombinant Human Hyaluronidase)

Provider Order Form rev 7/30/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Primary Immunodeficiency: Chronic Inflammatory Demyelinating Polyneuropathy:

Other:

THERAPY ADMINISTRATION *(Select one)*

Chronic Inflammatory Demyelinating Polyneuropathy

•Doses less than or equal to 0.4 g/kg can be administered without ramp-up

• Patients must be on stable doses of IVIG for 12 weeks before switching to HYQVIA

☐ Patients transitioning from IVIG tx, administer HyQvia at the same dose and frequency as the previous IV tx, after the initial dose ramp-up as indicated per the manufacturer.

Dose_____GM subcutaneously

Frequency: ☐every 2 weeks/ ☐every 3 weeks☐/every 4 weeks

Primary Immunodeficiency

☐ Patients transitioning from IVIG tx, administer HyQvia at the same dose and frequency as the previous IV tx, after the initial dose ramp-up as indicated per the manufacturer.

Dose: _____GM subcutaneously

Frequency: ☐every 3 weeks☐/every 4 weeks

☐ New to SCIG treatment or transitioning from SCIG, administer HyQvia at 300mg/kg to 600mg/kg at 3- or 4-week intervals, after the initial ramp up as indicated by the manufacturer.

Dose: _____GM subcutaneously

Frequency: ☐ every 3 weeks/ ☐ every 4 weeks.

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ CBC w/ diff ☐ at each dose ☐ every: _____

☐ CMP ☐ at each dose ☐ every: _____

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Solumedrol ☐ 40mg / ☐ 125mg IVP

☐ Other: _____

NURSING

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

Ramp Up Schedule			
CIDP ramp up	PI ramp up if switching from IVIG	Ramp up if switching from SCIG or new to SCIG	
Wk **1**-no tx	Wk **1** total gmX0.25	3 weeks	4 weeks
Wk **2&3** total gm x0.25	Wk **2** total gmX0.5	Wk **1** total gmX0.33	Wk**1** total gmx0.25
Wk **4** total gm X0.50	Wk **4** total gmX0.75	Wk **2** total gmx0.67	Wk**2** total gmx0.5
Wk **6** total gm x0.75	Wk **7** total dose	Wk **4** total dose	Wk **4** total gmX0.75
Wk **9** total dose			Wk **7** total dose

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications. EMG (dx CIDP)

Required Labs: Immunoglobulin levels, Renal function, CRP/ESR, ANA,

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.