

PATIENT INFORMATION
 Demographics attached

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION /MEDICAL CARD(S), FRONT AND BACK
MEDICAL INFORMATION

Diagnosis: _____ ICD-10 Code: _____

Allergies: _____

 Clinical/Progress Notes, Labs (CMP), Tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: Infusion Clinic Referring Physician

Lab Orders: _____

HYQVIA ORDERS
 Patient switching from Immune Globulin Intravenous (Human) [IVIG] treatment: Administer HYQVIA at the same dose and frequency as the previous intravenous treatment, after the initial ramp-up.

 Patient naive to IgG treatment or switching from Immune Globulin Subcutaneous (Human) [IGSC]: Administer HYQVIA at 300 to 600 mg/kg at 3 to 4 weeks intervals, after the initial ramp-up. Dose after ramp-up _____ gm Q _____ weeks.

Patient Weight: _____ kg X Ordered Dose _____ mg/kg / 1000 = Total Grams: _____ grams X 10 = Volume: _____ mL

 Number of infusion sites: One (1) infusion site One (1) - Two (2) infusion site(s)

 Infusion Site: Abdomen Thigh Other: _____

Treatment Interval and ramp up schedule: For patients previously on another IgG treatment, the first dose should be given approximately one week after the last infusion of their previous treatment. Last dose given: _____

 Treatment Interval 4 weeks 3 weeks

| | Week 1 | Week 2 | Week 4 | Week 7 |
|--------------|--------------|--------------|--------------|-------------|
| 1st Infusion | Grams X 0.25 | Grams X 0.50 | Grams X 0.75 | Total Grams |
| 2nd Infusion | Grams X 0.33 | Grams X 0.67 | Total Grams | N/A |
| 3rd Infusion | | | | |
| 4th Infusion | | | | |

Infusion parameters for Recombinant Human Hyaluronidase (HY & Immune Globulin Infusion 10% (IG) 1

 Rate of administration for HY: 1-2 mL/min/site(s) or as tolerated

Rate of administration for IG:

 Subjects < 40 kg (<88 lbs)

 Subjects > 40 kg (>88 lbs)

| Intervals (minutes) | Rate per site (mL/hour) | | | |
|-----------------------|-------------------------|-----------------------------|-------------------|-----------------------------|
| | First 2 Infusions | Subsequent 2 or 3 Infusions | First 2 Infusions | Subsequent 2 or 3 Infusions |
| 5 - 15 | 5 | 10 | 10 | 10 |
| 5 - 15 | 10 | 20 | 30 | 30 |
| 5 - 15 | 20 | 40 | 60 | 120 |
| 5 - 15 | 40 | 80 | 120 | 240 |
| 5 - 15 | 80 | 160 | 240 | 300 |
| Remainder of infusion | 5 | 10 | 10 | 10 |

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____

Phone: _____ Fax: _____ Contact Person: _____

INFUSION CENTER LOCATIONS
Phone: 877-365-5566
Fax: 855-889-2946
Texas
 Arlington Austin Dallas Houston North Hills
 Plano Round Rock San Antonio Stone Oak

Tennessee
 Knoxville

Georgia
 Atlanta