PARAGON
INFUSION CENTERS

HYQVIA
INFUSION ORDERS

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) [IGIV] treatment: Administer HYQVIA at the same does and frequency as the previous intravenous treatment, after the initial ramp-up.

☐ Patient naïve to IgG treatment or switching from Immune Globulin Subcutaneous (Human) [IGSC]: Administer HYQVIA at 300 to 600 mg/kg at 3 to 4 week 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
1st Infusion	Week 1	Grams X 0.25	Grams X 0.33
2nd Infusion	Week 2	Grams X 0.50	Grams X 0.67
3rd Infusion	Week 4	Grams X 0.75	Total Grams
4th Infusion	Week 7	Total Grams	N/A

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)	
	First 2 Infusions	Subsequent 2 or 3 Infusions	First 2 Infusions	Subsequent 2 or 3 Infusions
Intervals (minutes)	Rate per site (mL/hour)			
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 LOCATION

☐ Arlington	☐ Austin	☐ Dallas	☐ Houston	☐ Knoxville	☐ North Hills	☐ Plano	☐ Round Rock	☐ San Antonio	☐ Stone Oak
P: 817.200.2530	P: 512.261.4800	P: 972.408.2777	P: 713.860.1755	P: 865-299-7525	P: 817.284.2700	P: 469-974-0565	P: 737-443-5230	P: 210.366.4358	P: 210.485.3700
F: 817.509.0011	F: 512.261.4803	F: 469.913.6894	F: 713.277.7219	F: 865-338-5604	F: 817.284.2701	F: 469-608-2072	F: 737-402-7698	F: 210.366.4896	F: 210.390.1738

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