HIZENTRA 20% Order Form

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

☐ **Demographics Attached**

Patient Name: _____ **DOB:** _____ **Phone:** _____

INSURANCE INFORMATION: Please attach a copy of insurance cards (front and back).

Medical Information

Diagnosis: ☐ Primary immunodeficiency ICD-10 Code: _____

☐ Chronic inflammatory demyelinating polyneuropathy ICD-10 Code: _____

☐ Other: _____ ICD-10 Code: _____

Patient Weight: _____ lbs. Allergies: _____

☐ Clinical/progress notes, labs and tests supporting primary diagnosis attached

☐ **Required Labs:** Renal function (Cr, BUN)

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

Lab Orders: _____

Hizentra Infusion Orders

Primary Immunodeficiency Dosing

☐ Weekly dosing:

- Start 1 week after IVIG infusion
- _____ grams Sub-Q weekly

☐ Biweekly dosing (every 2 weeks):

- Start 1 or 2 weeks after the last IVIG Infusion or 1 week after the last weekly IGSC infusion
- _____ grams Sub-Q every 2 weeks

☐ Frequent dosing (2 to 7 times per week):

- Start 1 week after last IVIG or IGSC infusion
- _____ grams Sub-Q _____ days per week

CIPD Dosing

☐ Weekly dosing:

- Initiate therapy 1 week after the last IVIG infusion
- _____ grams Sub-Q weekly

Physician Information

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

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other _____

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