AYSA
THERAPEUTICS INFUSION

HIZENTRA 20% ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (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 one week after IVIG infusion
- _____ grams subQ 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 subQ every 2 weeks

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

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

CIPD DOSING

☐ Weekly Dosing:

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

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, 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: _____ Physician Name: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____