



**AYSAs**

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: \_\_\_\_\_

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