BIOMATRIX SpRx

HYQVIA® REFERRAL FORM (PAGE 1 OF 2)

TODAY'S DATE ______________

☐ CURRENT PATIENT ☐ NEW PATIENT

PLEASE FAX REFERRAL FORM TO:

☐ BiologicTx - NJ TEL: 877-567-8087 FAX: 877-567-8089
☐ BiologicTx - CA TEL: 800-404-1963 FAX: 800-404-4595
☐ BiologicTx - IL TEL: 888-892-7607 FAX: 877-567-8089
☐ Decillion Healthcare TEL: 800-622-9321 FAX: 866-548-8849
☐ Elwyn Specialty Care TEL: 855-359-9679 FAX: 610-545-6030
☐ Factor Support Network TEL: 877-376-4968 FAX: 805-482-6324
☐ Matrix Health TEL: 877-337-3002 FAX: 888-385-2805
☐ Med Center Specialty Pharmacy TEL: 855-633-5633 FAX: 304-344-0655
☐ MedEx BioCare TEL: 800-962-6339 FAX: 901-382-3091

Patient Name ______________ SS# ______________ DOB ______________ ☐ Male ☐ Female
Street Address ______________ Apt# ______ City ______________ State ______ Zip ______
Daytime Tel ______________ Cell ______________ Email ______________ Height ______ Weight ______ BSA ______
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office Local Pharmacy Phone ______________
Allergies ______________ Comorbidities ______________
Current Medications (if necessary, please fax a complete list) ______________

PRACTICE NAME	ADDRESS	PHONE	PRIMARY CONTACT

PRESCRIBER INFORMATION (PLEASE INCLUDE PHYSICIAN NAME AND NPI#)

☐ ______________ # ______ ☐ ______________ # ______ ☐ ______________ # ______
☐ ______________ # ______ ☐ ______________ # ______ ☐ ______________ # ______
☐ ______________ # ______ ☐ ______________ # ______ ☐ ______________ # ______

Insured's Name ______________ Relation to Patient ______________
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# ______________ Prescription Card ☐ Yes ☐ No If Yes, Carrier ______________
Tel ______________ Fax ______________ Policy/Group# ______________
Bin# ______________ Pcn# ______________ RXID# ______________ RX Group# ______________

ICD-10 Code

☐ D80.0 Hereditary Hypogammaglobulinemia
☐ D80.5 Immunodeficiency with Increased immunoglobulin M(IgM)
☐ D81.0 Severe Combined Immunodeficiency with Reticular Dysgenesis
☐ D81.1 Immunodeficiency with Low T- and B-Cell Numbers
☐ D81.2 Severe Combined Immunodeficiency with Low or Normal T- and B-Cell Numbers
☐ D81.6 Major Histocompatability Complex Class 1 Deficiency
☐ D81.7 Major Histocompatability Complex Class 2 Deficiency
☐ D81.89 Other Combined Immunodeficiencies
☐ D81.9 Combined Immunodeficiency, Unspecified
☐ D82.0 Wiskott-Aldrich Syndrome
☐ D83.0 CVID with Predom Abnlt of B-Cells numbers and functions
☐ D83.2 CVID with Autoantibodies to B- or T-Cells
☐ D83.8 Other Common Variables
☐ D83.9 Common Variable Immunodeficiency, Unspecified

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PHYSICIAN ORDERS – SCIg THERAPY (Pharmacy to provide pump and necessary supplies for administration of SCIg)

☐ New Patient ☐ Continuing Patient ☐ Conversion Patient

☐ Patient switching from Immune Globulin Intravenous (Human) [IVIG] treatment:
Administer HYQVIA at the same dose and frequency as the previous intravenous treatment, after initial ramp-up[1].

☐ 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 initial ramp up[1].

Patient Weight: ______ kg x Ordered Dose: ______ mg/kg ÷ 1000 = Total Grams: ______ gm x 10 = Volume ______ mL

Pharmacy to calculate infusion parameters per package insert (PI) recommendations ______ Refills *(as allowed by state or payer requirement)*

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

Infusion Site: ☐ Abdomen ☐ Thigh ☐ Other: ______________

High flow 24 G needle length: ☐ 6mm ☐ 9mm ☐ 12mm ☐ 14mm - *the needle gauge and length may be adjusted as necessary for patient comfort or preference*

☐ Peristaltic pump ☐ Syringe driver pump ☐ Provide pump and related infusion supplies
☐ Prescriber alternate instruction: ______________

Additional Services: ☐ Provide needles, syringes, VAD supplies & other ancillary supplies needed for infusion
☐ DME – Infusion pump with supplies ☐ Pharmacy to provide anaphylactic kit: ______________

TREATMENT INTERVAL AND RAMP UP SCHEDULE[1]

For patients previously on another IgG treatment, the first dose should be given approximately one week after the last infusion of their previous treatment.

Treatment Interval:		☐ 4 weeks	☐ 3 weeks
1st infusion	1st week	Grams x 0.25	Grams x 0.33
2nd infusion	2nd week	Grams x 0.50	Grams x 0.67
3rd infusion	4th week	Grams x 0.75	Total Grams
4th infusion	7th week	Total Grams	n/a

COMPLETE PAGE 2 WITH CLINICAL INFORMATION

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HYQVIA® REFERRAL FORM (PAGE 1 OF 2)

Patient Name ____ DOB ________________

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

INFUSION PARAMETERS FOR RECOMBINANT HUMAN HYALURONIDASE (HY) AND 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)	Rate per site (mL/hour)	Rate per site (mL/hour)	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
Remainder of infusion	80	160	240	300

PRE-MED ORDERS

Apply topically to skin 30 minutes prior to subcutaneous needle insertion.

☐ Emla 2.5% Cream ☐ LMX -4 Cream ☐ Other Medications:________________________________

Will dispense generically unless MD specifies brand by initialing Dispense As Written (initial):____________ Brand:________________

ANAPHYLAXIS/FLUSH/SUPPLY ORDERS

Anaphlylaxis Kit: ☐ Adult EpiPen 0.3mg/0.3mL Auto-Injector ☐ Pediatric EpiPen Jr. 0.15mg/0.3mL Auto-Injector

Will dispense generically unless MD specifies brand by initialing Dispense As Written (initial):____________ Brand:________________

NURSING ORDERS

☐ Provide skilled nursing care to instruct administration of SCIg therapy.
☐ Nurse to complete physical assessment including vital signs with each visit.
☐ Provide education regarding medication, disease state, adverse drug reactions and procedures, pump and pump care, & administration.
☐ Observe for response to therapy.
☐ Patient to be discharged from nursing once independent with therapy administration.

COMMENTS ____

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By signing this form and utilizing our services, you are authorizing BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS)__________ *Dispense as written* __________ **Date**____________________

Prescriber's Signature (signature required. NO STAMPS)__________ *Product Substition Permitted* __________ **Date**____________________

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