alera care
advanced infusion centers™

**FAX 833.329.4738**

**Subcutaneous Immune Globulin (SCIG)**

Provider Referral Form rev. 5/5/2023

## Patient Information

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

NKDA Allergies: Weight lbs/kg: Height:

Patient Status: New to Therapy Continuing Therapy Therapy Change Last infusion date (if applicable): ____________________

Is the patient pregnant, planning a pregnancy or nursing: Yes No Does the patient need interpreter services: Yes No

## Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

## ICD-10 CODE

D80.9 Primary humoral immunodeficiency (PI)

D81.9 Combined immunodeficiency

D82.0 Wiskott-Aldrich syndrome

D83.9 Common variable immunodeficiency/agammaglobulinemia

G61.81 Chronic inflammatory demyelinating polyneuropathy (CIDP)

Other: ______________________________________________________________________________

## Documentation Required (Note: Send all labs, must include specific labs listed here)

Labs Insurance Card (front and back) Current Medications History/Progress Notes

## Medication Order

### Hyqvia

(Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase)

**Dose and Frequency:**

___________ grams SC every ______ weeks

______ mg/kg SC every ______ weeks

Other: ____________________________

Ramp up and maintenance dose: Patient is new to Hyqvia treatment. Follow ramp up schedule per chart with the indicated dose, then continue to the maintenance dose.

| Treatment Interval | Dosing Frequency: 4 weeks | Dosing Frequency: 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 Dose (maintenance dose) |
| 4th Infusion (Week 7) | Total Dose (maintenance dose) | |

Alternative ramp up schedule: ____________________________

Maintenance dose only: Patient is currently on Hyqvia.

## Pre-Medication Order

**acetaminophen** (Tylenol) 500mg 650mg 1000mg PO

**diphenhydramine** (Benadryl) 25mg 50mg / PO IV

**cetirizine** (Zyrtec) 10mg PO

**methylprednisolone** (Solu-Medrol) 40mg IV 125mg IV

**loratadine** (Claritin) 10mg PO

**hydrocortisone** (Solu-Cortef) 100mg IV

Other: ______________________________________________________________________________

Dose: __________________ Route: __________________ Frequency: __________________

## Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

**Provider Name** **Provider Signature** **Date**

Order Expiration Date (mm/dd/yy): __________________ (If not indicated order will expire one year from date signature) Check here if this is a stat order

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**(Currently only available in Arizona)**

## Patient Information

| Patient Name: | DOB: Sex: M F Fasting: Y N |
|---|---|
| Patient Home Phone: | Patient Cell Phone: |
| Emergency/Alternate Contact Name: | Emergency/Alternate Contact Phone: |

## Lab Test (Please circle or write in ICD-10)

| Lab Test | ICD-10 | Lab Test | ICD-10 |
|---|---|---|---|
| ALT | R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21 | HIV VIRAL LOAD | Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20 |
| AST | R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21 | IgE | J45.4, J45.3, L50.9, J45.40, J45.50 |
| HEPATIC FUNCTION PANEL | R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21 | IgG | G35, G36.0 |
| BASIC METABOLIC PANEL | I10, E87.1, Z79.899, E87.5, E80.20, G35, M81.0, M81.8, N18.9 | IMMUNOGLOBULIN QUANT IgG, IgM, IgA | G35, G36.0 |
| CALCIUM | M81.0, M81.8 | IMMUNOGLOBULIN QUANT IgG, IgM, IgA, IgE | G35, G36.0 |
| CBC (INCLUDES DIFF/PLT) | I10, D64.9, Z00.00, R53.83, G35, C50.011, D70.9, D50.0, D63.1 | IRON, TIBC, FER PNL | D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9 |
| CBC (H/H, RBC, WBC, PLT)s | I10, Z00.00, Z13.0, D64.9, G35, C50.011, D70.9, D50.0, D63.1 | LIPID PANEL | Z79.899, E78.5, E55.9, E78.00, Z00.00, E78.01, E78.2 |
| COMP METABOLIC PANEL | I10, Z79.899, E78.5, E11.9, E78.2, E80.20, G35, M81.0, M81.8, N18.9 | MAGNESIUM | I10, Z79.899, R25.2, E83.42, Z00.00 |
| CREATININE | M81.0, M81.8, G35 | PSA | R97.20, C61, N40.1, Z12.5, N40.0 |
| C-REACTIVE PROTEIN (CRP) | R53.83, R79.82, M35.3, I10, M06.9, K50.90, K51.90, M32.9, L40.50 | PROTHROMBIN TIME-INR | Z79.01, I48.91, I48.0, Z51.81 |
| FERRITIN | D64.9, D50.9, D50.0, D50.8, Z00.00, D63.1, N18.9 | TRANSFERRIN SATURATION | D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9 |
| G6PD | M1A.9XX0, M1A.9XX1 | QUANTIFERON TB GOLD | Z79.899, Z00.00, Z01.84, M06.9, M08.9, M45.0, L40.0, L40.50, K51.90, K50.90 |
| GROWTH HORMONE | E22, C7A.1, E34 | TSH | E03.9, I10, E03.8, R53.83, E06.3, E05.00 |
| HBSAG CONFIRMATION | Z11.3, Z36.9, Z20.2, Z11.59, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0 | URIC ACID | M10.9, E79.0, I10, Z00.00, M1A.9XX0, M1A.9XX1 |
| HEMOGLOBIN & HEMATOCRIT | D50.9, D64.9, D50.0, D63.1, N18.9 | VIT B12/FOLIC ACID | M89.49, E53.8, R53.83, F41.8, F41.9, E05.00 |
| HEMOGLOBIN A1C | E11.9, E11.65, R73.01, Z00.00, I10 | VIT D 25- HYDROX | E55.9, Z00.00, R53.83, I10, Z79.899, M81.0, M81.8 |
| HEP B SURF AG | Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0 | Miscellaneous Labs Not Listed (Write In) | |
| HIV 4TH GEN | Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20 | | |
| HIV 1/2 AB DIFF | Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20 | | |

## Frequency

Prior to each dose    Yearly    Other: Please Specify Below

Lab Test: ____________________ Frequency: ____________________

Lab Test: ____________________ Frequency: ____________________

Lab Test: ____________________ Frequency: ____________________

Lab Test: ____________________ Frequency: ____________________

**Provider Name**    **Provider Signature**    **Date**

**Provider Phone**