Provider Order Form

HIZENTRA (IMMUNE GLOBULIN SUBCUTANEOUS)

Uptiv Health

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX

PATIENT

Full Name: DOB:

Mobile Phone: Weight: ☐ lbs ☐ kg

Allergies: ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Nonfamilial hypogammaglobulinemia D80.1
☐ Primary Immunodeficiency (PI) D80.0
☐ Chronic inflammatory demyelinating polyneuropathy (CIDP) G61.81
☐ Other: _____

PROVIDER

Provider Name: Provider NPI:

Practice Name: Referral Coordinator Name:

Practice Address:

Phone: Fax: Email:

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg
☐ Diphenhydramine (Benadryl) PO ☐ 25 mg ☐ 50 mg
☐ Dexamethasone PO ☐ 20 mg
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☒ Hizentra (Immune Globulin Subcutaneous)	☐ 0.2g/kg ☐ 0.4g/kg ☐ Total dose _____	☐ Infuse subcutaneously every _____ days or every _____ weeks. ☐ Other: _____

Refills ☐ Zero ☐ 12 months ☐ _____ Order valid for 1 year unless otherwise stated. _____

☒ Flush with 0.9% sodium chloride at infusion completion. Inject over 10 minutes

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other _____ ☐ at each dose ☐ every _____

SPECIAL INSTRUCTIONS

Provider Signature Date