**Sample Coverage Request Letter**

Medical Director Name
Address

RE:
ID:
GROUP:

Dear ________:

I am writing to inform you that I have recommended replacement of conventional subcutaneous immunoglobulin supplementation therapy with enzyme facilitated subcutaneous immunoglobulin infusion using HyQvia for this patient. This change is recommended:

[Include justification here.]

Note that in contrast to conventional subcutaneous immunoglobulin infusion, no dose adjustment is recommended for HyQvia when compared to intravenous immunoglobulin.

Diagnosis:
Drug:
Ramp up schedule will comprise the following:

Week #1: __ grams
Week #2: __ grams
Week #4: __ grams
Week #7 and every 4 weeks thereafter: __ grams

Duration of therapy:

Thank you for your prompt attention to this matter. If you require further information, please contact me.

Sincerely,

___________

Please note the HyQvia NDC codes:
0944251002 25mL
0944251102 50mL
0944251202 100mL
0944251302 200mL
0944251402 300mL