HyQvia
[Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase]

PRESCRIPTION REFERRAL FORM

PREVENT SUBSTITUTIONS
Write "Dispense as Written"

Fax completed form to (855) 217-1619

HOW CAN MYIGSOURCE HELP YOU? ☐ Register Only ☐ New Patient ☐ Continuing Patient ☐ Conversion Patient ☐ Co-Pay Card ☐ Smart Start ☐ BV Only

SECTION A PATIENT INFORMATION (REQUIRED)

PATIENT NAME: DATE OF BIRTH: SEX (M/F):

ADDRESS: CITY: STATE: ZIP:

TELEPHONE: E-MAIL:

PARENT/GUARDIAN NAME: DIAGNOSIS CODES: *LIST PRINCIPAL DIAGNOSIS FIRST*

REQUIRED IF PATIENT IS YOUNGER THAN 18 YEARS

☐ ENGLISH IS 2ND LANGUAGE PRIMARY LANGUAGE: CURRENT TREATMENT:

SECTION B INSURANCE INFORMATION

If benefits processing is requested, please provide a copy (front & back) of insurance card or of any medical and/or prescription cards.

SECTION C PRESCRIBER PREFERENCE

PREFERRED SITE OF CARE (MARK ONE):
○ Infusion suite ○ Hospital outpatient ○ Prescriber's office ○ Home infusion ○ Begin treatment in clinical setting, then transition to homecare

PREFERRED INFUSION PROVIDERS: SPECIALTY PHARMACY/HOMECARE COMPANY TO TRAIN PATIENT? ○ YES ○ NO

WOULD YOU LIKE THE INFUSION PROVIDER TO CONTACT YOU REGARDING NURSING NOTES/PHARMACY PROGRESS REPORTS ON THE STATUS OF THE PATIENT? ○ YES ○ NO

SECTION D PRESCRIPTION & MEDICAL ORDERS

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

Patient weight: _____ kg X Ordered Dose: _____ mg/kg ÷ 1000 = Total Grams: _____ grams X 10 = Volume: _____ mL

☐ Pharmacy to calculate infusion parameters per package insert (PI) recommendation

_____ Refills (as allowed by state or payer requirement)

☐ Prescriber alternate instruction: _____

☐ _____

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 : ☐ 6 mm ☐ 9 mm ☐ 12 mm ☐ 14 mm

☐ Peristaltic pump ☐ Syringe driver pump ☐ Provide pump and related infusion supplies

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

Infusion parameters for Recombinant Human Hyaluronidase (HY) and Immune 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

SECTION E PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME: OFFICE CONTACT:

ADDRESS: CITY: STATE: ZIP:

TELEPHONE: FAX: E-MAIL:

FACILITY OR PRESCRIBER TAX ID #: DEA #: NPI #:

PLEASE NOTE: TWO SIGNATURES ARE REQUIRED

- I verify that the patient has been informed of the diagnosis listed in Section A of this form.
- I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed HYQVIA based on my professional judgment of medical necessity. I authorize Baxter Healthcare Corporation and its affiliated companies, agents and representatives, and contracted third parties ("Baxter and Baxter Parties") to contact my patient regarding Baxter programs, and to forward this prescription electronically, by facsimile, or by mail to the dispensing pharmacy selected above (if applicable). I authorize the dispensing pharmacy to share information with Baxter and Baxter Parties about this patient. I also authorize Baxter and Baxter Parties to perform any steps necessary to obtain reimbursement for HYQVIA, including but not limited to insurance verification and case assessment. I understand that additional information may be required, and I agree to provide it as needed for the purposes of reimbursement.

☐ **DISPENSE AS WRITTEN** Exact terminology may be based on state regulations. Please provide state-specific prescription language here: _____

PRESCRIBER SIGNATURE (REQUIRED): DATE: EN (FOR INTERNAL PURPOSES ONLY):

PRESCRIBER AUTHORIZATION (REQUIRED)

By signing below, I certify that I have received the necessary written authorization from the patient to release the medical and/or patient information referenced on this form relating to the above-referenced patient to Baxter Healthcare Corporation and its affiliated companies, agents and representatives, and contracted third parties for all of the purposes I authorize above, including seeking reimbursement support, verifying insurance coverage and/or the evaluation of the patient's eligibility for alternate sources of funding, contacting the patient for the purpose of enrollment in Baxter patient support services, and to facilitate materials fulfillment and product fulfillment via dispensing pharmacies.

PRESCRIBER SIGNATURE (REQUIRED): DATE:

For more information, call MyIgSource at 855-250-5111 or visit www.HYQVIA.com

Please see the Indication and Detailed Important Risk Information on reverse side of this form and the accompanying full Prescribing Information, including boxed warning.

Baxter

HyQvia
[Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase]

INDICATIONS

HYQVIA is an immune globulin with a recombinant human hyaluronidase indicated for the treatment of Primary Immunodeficiency (PI) in adults. This includes, but is not limited to, common variable immunodeficiency (CVID), X-linked agammaglobulinemia, congenital agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies.

Limitation of Use:
Safety and efficacy of chronic use of recombinant human hyaluronidase in HYQVIA have not been established in conditions other than PI.

IMPORTANT RISK INFORMATION

BOXED WARNING: THROMBOSIS

Thrombosis may occur with immune globulin products, including HYQVIA. Risk factors may include advanced age, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling vascular catheters, hyperviscosity, and cardiovascular risk factors. Thrombosis may occur in the absence of known risk factors. For patients at risk of thrombosis, administer HYQVIA at the minimum dose and infusion rate practicable. Ensure adequate hydration in patients before administration. Monitor for signs and symptoms of thrombosis and assess blood viscosity in patients at risk of hyperviscosity.

CONTRAINDICATIONS

HYQVIA is contraindicated in patients who have a history of anaphylactic or severe systemic reactions to the administration of IgG; in IgA-deficient patients with antibodies to IgA and a history of hypersensitivity; and in patients with known systemic hypersensitivity to hyaluronidase or Recombinant Human Hyaluronidase of HYQVIA.

WARNINGS and PRECAUTIONS

Hypersensitivity: Severe hypersensitivity reactions may occur, even in patients who have tolerated previous treatment with IgG. Patients with antibodies to IgA are potentially at greater risk of developing potentially severe hypersensitivity and anaphylactic reactions. In case of hypersensitivity, discontinue HYQVIA infusion immediately and institute appropriate treatment.

Thrombosis: Thrombosis may occur following treatment with immune globulin products, including HYQVIA. Risk factors may include advanced age, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling central vascular catheters, hyperviscosity, and cardiovascular risk factors. Thrombosis may occur in the absence of known risk factors. Consider baseline assessment of blood viscosity in patients at risk of hyperviscosity.

Immunogenicity of Recombinant Human Hyaluronidase (PH20)
Non-neutralizing antibodies to the recombinant human hyaluronidase component may develop. The potential exists for such antibodies to cross-react with endogenous PH20, which is known to be expressed in adult male testes, epididymis, and sperm. It is unknown whether these antibodies may interfere with fertilization in humans. The clinical significance of these antibodies is unknown.

Aseptic Meningitis Syndrome (AMS): AMS has been reported to occur with IgG products, including Immune Globulin Infusion 10% (Human) administered intravenously and subcutaneously. Discontinuation of IgG treatment has resulted in remission of AMS within several days without sequelae. The syndrome usually begins within several hours to two days following intravenously administered IgG, perhaps more frequently in association with high dose (2 g/kg) intravenously administered IgG. Conduct a thorough neurological examination on patients exhibiting symptoms and signs, including cerebrospinal fluid studies, to rule out other causes of meningitis.

Hemolysis: IgG products, including HYQVIA, contain blood group antibodies which may cause a positive direct antiglobulin reaction and hemolysis. Acute intravascular hemolysis has been reported following administration of IgG products, including Immune Globulin Infusion 10% (Human) administered intravenously, and delayed hemolytic anemia can develop due to enhanced RBC sequestration. Monitor patients for clinical signs and symptoms of hemolysis.

Renal Dysfunction/Failure: Acute renal dysfunction/failure, acute tubular necrosis, proximal tubular nephropathy, osmotic nephrosis, and death may occur upon administration of IgG products administered intravenously, especially those containing sucrose. HYQVIA does not contain sucrose. Ensure that patients are not volume depleted prior to the initiation of infusion of HYQVIA. Monitor renal function and consider lower, more frequent dosing in patients who are at risk of developing renal dysfunction because of pre-existing renal insufficiency or predisposition to acute renal failure. Periodic monitoring of renal function and urine output is particularly important in patients judged to be at increased risk for developing acute renal failure.

Spread of Localized Infection: Do not infuse HYQVIA into or around an infected or acutely inflamed area due to potential risk of spreading a localized infection.

Transfusion-Related Acute Lung Injury (TRALI): Non-cardiogenic pulmonary edema has been reported in patients following treatment with intravenously administered IgG products, including Immune Globulin Infusion 10% (Human). TRALI is characterized by severe respiratory distress, pulmonary edema, hypoxemia, normal left ventricular function, and fever. Monitor patients for pulmonary adverse reactions.

Transmittable Infectious agents: Because the Immune Globulin Infusion 10% (Human) of HYQVIA is made from human plasma, it may carry a risk of transmitting infectious agents, e.g., viruses, the variant CJD (vCJD) agent, and theoretically, the Creutzfeldt-Jakob disease (CJD) agent. This also applies to unknown or emerging viruses and other pathogens. No cases of viral transmission or CJD have been associated with HYQVIA.

Interference with Laboratory Tests: False positive serological test results, with the potential for misleading interpretation, may result from the transitory rise of the various passively transferred antibodies in the patient's blood after infusion of IgG. Passive transmission of antibodies to erythrocyte antigens (e.g., A, B, and D) may cause a positive direct or indirect antiglobulin (Coombs') test.

ADVERSE REACTIONS

The most common adverse reactions observed in >5% of patients in the clinical trials were: local adverse reactions (52%), headache (21%), antibody formation against recombinant human hyaluronidase (18%), fatigue (11%), nausea (7%), pyrexia (7%), and vomiting (7%). No serious adverse reactions occurred during the HYQVIA clinical trials

Please see the accompanying full Prescribing Information, including boxed warning

The information you provide will be used to administer support services and information on Baxter's programs, therapies, services to you and your patient, and clinical studies. We may share the information provided with our partners who facilitate the verification and delivery of this information. If you ever decide that you do not wish to receive information from us regarding our therapies and services, contact us at: Consumer Relations, Baxter Healthcare Corporation, One Baxter Parkway, Deerfield, IL 60015 or at 800-241-9360. If you have any questions, comments, concerns, or complaints about our information practices, call 1-800-422-9837 (U.S.) or 847-948-4770 (outside of the U.S.), fax your inquiry to 847-948-3642, or send us mail at Center for One Baxter, One Baxter Parkway, Deerfield, IL 60015.

This form is designed to facilitate the compliance of HIPAA as well as other privacy laws.

Reference: 1. HYQVIA [prescribing information]. Westlake Village, CA: Baxter Healthcare Corporation. September 2014.

October 2014 USBS/MG89/14-0039(1)

Baxter

GAMMAGARD LIQUID
[Immune Globulin Infusion (Human)] 10%

PRESCRIPTION REFERRAL FORM

PREVENT SUBSTITUTIONS
Write "Dispense as Written"

Fax completed form to (855) 217-1619

HOW CAN MYIGSOURCE HELP YOU? ☐ Register Only ☐ New Patient ☐ Continuing Patient ☐ Conversion Patient ☐ Co-Pay Card ☐ Refer to Homecare ☐ BV Only

SECTION A
PATIENT INFORMATION (REQUIRED)

PATIENT NAME: _____ DATE OF BIRTH: _____ SEX (M/F): _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: _____ E-MAIL: _____

PARENT/GUARDIAN NAME: _____ **DIAGNOSIS CODES:** *LIST PRINCIPAL DIAGNOSIS FIRST* _____

REQUIRED IF PATIENT IS YOUNGER THAN 18 YEARS

☐ ENGLISH IS 2ND LANGUAGE PRIMARY LANGUAGE: _____ **CURRENT TREATMENT:** _____

SECTION B
INSURANCE INFORMATION

If benefits processing is requested, please provide a copy (front & back) of insurance card or of any medical and/or prescription cards.

PRIMARY INSURANCE: _____

TELEPHONE: _____ FAX: _____

INSURED'S NAME: _____

RELATIONSHIP TO PATIENT: _____ EMPLOYER: _____

GROUP #: _____ IDENTIFICATION #: _____

SECONDARY INSURANCE: _____

TELEPHONE: _____ FAX: _____

INSURED'S NAME: _____

RELATIONSHIP TO PATIENT: _____ EMPLOYER: _____

GROUP #: _____ IDENTIFICATION #: _____

SECTION C
PRESCRIBER PREFERENCE

PREFERRED SITE OF CARE (MARK ONE):

◯ Infusion suite ◯ Hospital outpatient ◯ Prescriber's office ◯ Home Infusion ◯ Begin treatment in clinical setting, then transition to homecare

PREFERRED INFUSION PROVIDERS: _____ SPECIALTY PHARMACY/HOMECARE COMPANY TO TRAIN PATIENT? ◯ YES ◯ NO

WOULD YOU LIKE THE INFUSION PROVIDER TO CONTACT YOU REGARDING NURSING NOTES/PHARMACY PROGRESS REPORTS ON THE STATUS OF THE PATIENT? ◯ YES ◯ NO

SECTION D
PRESCRIPTION & MEDICAL ORDERS

ROUTE OF ADMINISTRATION:

☐ **Subcutaneous administration (SCIG)**—For primary immunodeficiency (PI) patients switching from intravenous (IVIG) to subcutaneous treatment, the formula (right) is used to calculate the recommended initial dose.[1]

☐ **Intravenous administration (IVIG)**—For PI patients, intravenous immunoglobulin doses of 300 to 600 mg/kg every 3 to 4 weeks based on clinical response.[1]

SCIG DOSE = (1.37 X PREVIOUS IVIG DOSE) / (# OF WEEKS BETWEEN IVIG DOSES)

PATIENT WEIGHT: _____ ORDERED DOSE: _____ GRAMS _____ mg/kg/DOSE FREQUENCY: _____

ROUTE: ☐ Central IV ☐ Peripheral IV ☐ SC: Needle length, mm: _____ REFILLS: _____ times (as allowed by state or payor requirement)

OTHER MEDICATIONS: _____ DRUG ALLERGIES: _____

Additional services

☐ Provide needles, syringes, Venous Access Device (VAD) supplies & other ancillary supplies needed for infusion

☐ Durable Medical Equipment (DME)—Infusion pump with supplies

☐ Anaphylaxis kit: _____

SECTION E
PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME: _____ OFFICE CONTACT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: _____ FAX: _____ E-MAIL: _____

FACILITY OR PRESCRIBER TAX ID #: _____ DEA #: _____ NPI #: _____

PLEASE NOTE: TWO SIGNATURES ARE REQUIRED

- I verify that the patient has been informed of the diagnosis listed in Section A of this form.
- I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed GAMMAGARD LIQUID based on my professional judgment and medical necessity. I authorize Baxter Healthcare Corporation and its affiliated companies, agents and representatives, and contracted third parties ("Baxter and Baxter Parties") to contact my patient regarding Baxter programs, and to forward this prescription electronically, by facsimile, or by mail to the dispensing pharmacy selected above (if applicable). I authorize the dispensing pharmacy to share information with Baxter and Baxter Parties about this patient. I also authorize Baxter and Baxter Parties to perform any steps necessary to obtain reimbursement for GAMMAGARD LIQUID, including but not limited to insurance verification and case assessment. I understand that additional information may be required, and I agree to provide it as needed for the purposes of reimbursement.

☐ **DISPENSE AS WRITTEN** Exact terminology may be based on state regulations. Please provide state-specific prescription language here: _____

PRESCRIBER SIGNATURE (REQUIRED): _____ DATE: _____ EN (FOR INTERNAL PURPOSES ONLY): _____

PRESCRIBER AUTHORIZATION (REQUIRED)

By signing below, I certify that I have received the necessary written authorization from the patient to release the medical and/or patient information referenced on this form relating to the above-referenced patient to Baxter Healthcare Corporation and it's affiliated companies, agents and representatives, and contracted third parties for all of the purposes I authorize above, including seeking reimbursement support, verifying insurance coverage and/or the evaluation of the patient's eligibility for alternate sources of funding, contacting the patient for the purpose of enrollment in Baxter patient support services, and to facilitate materials fulfillment and product fulfillment via dispensing pharmacies.

PRESCRIBER SIGNATURE (REQUIRED): _____ DATE: _____

For more information, call MyIgSource at 855-250-5111 or visit www.gammagard.com

Please see the Indication and Detailed Important Risk Information on reverse side of this form and accompanying full Prescribing Information, including boxed warning.

Baxter

GAMMAGARD LIQUID

[Immune Globulin Infusion (Human)] 10%

Indication

GAMMAGARD LIQUID is indicated as replacement therapy for primary humoral immunodeficiency (PI) in adult and pediatric patients two years of age or older. This includes, but is not limited to, common variable immunodeficiency (CVID), X-linked agammaglobulinemia, congenital agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies.

Detailed Important Risk Information

WARNING: THROMBOSIS, RENAL DYSFUNCTION and ACUTE RENAL FAILURE

- **Thrombosis may occur with immune globulin products, including GAMMAGARD LIQUID. Risk factors may include advanced age, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling vascular catheters, hyperviscosity, and cardiovascular risk factors. Thrombosis may occur in the absence of known risk factors.**
- **Renal dysfunction, acute renal failure, osmotic nephrosis, and death may occur in predisposed patients with immune globulin intravenous (IGIV) products including GAMMAGARD LIQUID. Renal dysfunction and acute failure occur more commonly with IGIV products containing sucrose. GAMMAGARD LIQUID does not contain sucrose.**
- **For patients at risk of thrombosis, administer GAMMAGARD LIQUID at the minimum dose and infusion rate practicable. Ensure adequate hydration in patients before administration. Monitor for signs and symptoms of thrombosis and assess blood viscosity in patients at risk of hyperviscosity.**

CONTRAINDICATIONS

- GAMMAGARD LIQUID is contraindicated in patients who have a history of anaphylactic or severe systemic hypersensitivity reactions to the administration of human immune globulin. GAMMAGARD LIQUID is contraindicated in IgA-deficient patients with antibodies to IgA and a history of hypersensitivity.

WARNINGS and PRECAUTIONS

- **HYPERSENSITIVITY:** IgA deficient patients with antibodies to IgA are at greater risk of developing potentially severe hypersensitivity and anaphylactic reactions. In case of hypersensitivity, discontinue GAMMAGARD LIQUID infusion immediately and institute appropriate treatment.
- **RENAL DYSFUNCTION/FAILURE:** Monitor renal function, including blood urea nitrogen, serum creatinine, and urine output in patients at risk of acute renal failure. Ensure that patients with pre-existing renal insufficiency are not volume depleted. For patients at risk for renal dysfunction or thrombotic events, administer GAMMAGARD LIQUID at the minimum infusion rate practicable.
- **Hyperproteinemia, increased serum viscosity, and hyponatremia** may occur in patients receiving GAMMAGARD LIQUID.
- **THROMBOSIS:** Thrombosis may occur following treatment with immune globulin products, including GAMMAGARD LIQUID. Monitor for signs and symptoms of thrombosis and assess blood viscosity in patients at risk for hyperviscosity.
- **Aseptic Meningitis Syndrome** (AMS) may occur with IGIV treatment, and has been reported with intravenous (IV) use of GAMMAGARD LIQUID. AMS may occur more frequently with high dose (2 g/kg) IGIV treatment and/or rapid infusion of IGIV.
- **Hemolytic anemia** can develop subsequent to GAMMAGARD LIQUID treatment due to enhanced RBC sequestration. Risk factors may include: high doses (e.g., ≥2 g/kg cumulative dose), non-O blood group, and underlying inflammation. Monitor patients for clinical signs and symptoms of hemolysis and delayed hemolytic anemia.
- **Transfusion-Related Acute Lung Injury (TRALI)**: Non-cardiogenic pulmonary edema has been reported in patients following treatment with IGIV products, including GAMMAGARD LIQUID. Monitor patients for pulmonary adverse reactions.
- GAMMAGARD LIQUID is made from human blood. It may carry a risk of transmitting infectious agents, e.g., viruses, the variant Creutzfeldt-Jakob disease (vCJD) agent, and theoretically, the Creutzfeldt-Jakob disease agent. No confirmed cases of viral transmission or vCJD have been associated with GAMMAGARD LIQUID.
- Passive transfer of antibodies may transiently impair the immune responses to live attenuated virus vaccines such as mumps, rubella, varicella, and measles. This passive transfer may also yield false positive serological testing results, with the potential for misleading interpretation.

ADVERSE REACTIONS

The serious adverse reaction that occurred during the PI (IV administration) clinical trials was aseptic meningitis. No serious adverse reactions were observed during the PI subcutaneous (SC) administration clinical trial. The most common adverse reactions observed in ≥ 5% of patients in clinical trials were:

PI (IV administration): Headache, fatigue, pyrexia, nausea, chills, rigors, pain in extremity, diarrhea, migraine, dizziness, vomiting, cough, urticaria, asthma, pharyngolaryngeal pain, rash, arthralgia, myalgia, oedema peripheral, pruritus, and cardiac murmur.

PI (SC administration): Infusion site (local) event, headache, fatigue, heart rate increased, pyrexia, abdominal pain upper, nausea, vomiting, asthma, blood pressure systolic increased, diarrhea, ear pain, aphthous stomatitis, migraine, oropharyngeal pain, and pain in extremity.

Please see the accompanying full Prescribing Information, including Boxed Warning.

The information you provide will be used to administer support services and information on Baxter's programs, therapies and services to you and your patient. We may share the information provided with our partners who facilitate the verification and delivery of this information. If you ever decide that you do not wish to receive information from us regarding our therapies and services, contact us at: Consumer Relations, Baxter Healthcare Corporation, One Baxter Parkway, Deerfield, IL 60015 or at 800-241-9360. If you have any questions, comments, concerns, or complaints about our information practices, call 1-800-422-9837 (U.S.) or 847-948-4770 (outside of the U.S.), fax your inquiry to 847-948-3642, or send us mail at Center for One Baxter, One Baxter Parkway, Deerfield, IL 60015.

This form is designed to facilitate the compliance of HIPAA as well as other privacy laws.

Reference: 1. GAMMAGARD LIQUID [Immune Globulin Infusion (Human)] 10% [package insert]. Westlake Village, CA: Baxter Healthcare Corporation.

October 2014 USBS/1/13-0083(2)

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