Hy-Vee health™

ALLERGY / IMMUNOLOGY
Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: ____________________ **DOB:** __________ **Phone:** __________

Patient Status: New to Therapy Continuing Therapy **Next Treatment Date:** __________

Medical Information

Patient Weight: __________ lbs. (required) **Allergies:** ____________________

Therapy Order

Diagnosis	Infusion Orders		Refills
Persistent asthma (ICD-10 Code:_______) Chronic idiopathic urticaria (ICD-10 Code:_______) Nasal polyps (ICD-10 Code:_______)	**Xolair** 75 mg Sub-Q **Xolair** 150 mg Sub-Q **Xolair** 225 mg Sub-Q **Xolair** 300 mg Sub-Q **Xolair** 375mg Sub-Q **Xolair** 450 mg Sub-Q **Xolair** 525 mg Sub-Q **Xolair** 600 mg Sub-Q	**Xolair frequency:** Every 2 weeks Every 4 weeks	_______ x1 year
Severe asthma with eosinophilic phenotype (ICD-10 Code:_______) Severe granulomatosis with polyangiitis (ICD-10 Code:_______)	**Cinqair** 3 mg/kg IV every 4 weeks **Fasenra** initial dose: 30 mg Sub-Q every 4 weeks for the first 3 doses, followed by 30 mg Sub-Q every 8 weeks there after **Fasenra** 30 mg Sub-Q every 8 weeks **Nucala** 100 mg Sub-Q every 4 weeks **Nucala** 300 mg Sub-Q every 4 weeks **Tezspire** 210 mg Sub-Q every 4 weeks		_______ x1 year
Common variable immunodeficiency (ICD-10 Code:_______) Other: ____________ (ICD-10 Code:_______)	**Immunoglobulin:** **IV** **Sub-Q** _______ mg/kg **OR** _______ gm/kg x _______ day(s) **OR** divided over _______ day(s) **Frequency:** Every __________ weeks **OR** ____________________ *(Hy-Vee Health to choose if not indicated)* Brand: ____________________ Additional Ig orders: ____________________		_______ x1 year

Premedication orders: Tylenol 1000 mg 500 mg PO, please choose 1 antihistamine:
Diphenhydramine 25 mg PO Loratadine 10 mg PO Cetirizine 10 mg PO Quzyttir 10 mg IVP

Additional premedications: Solu-Medrol _____ mg IVP Solu-Cortef _____ mg IVP Other: ____________________

Lab orders: ____________________ **Frequency:** Every infusion Other: ____________________

Required labs to be drawn by: Hy-Vee Health Referring Provider

Physician Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Provider Name: ____________________ **Signature:** ____________________ **Date:** __________

Provider NPI: __________ **Phone:** __________ **Fax:** __________ **Contact Person:** __________

Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): ____________________

Service Areas

Des Moines, IA West Des Moines, IA Chicago, IL Omaha, NE Buffalo, NY Dallas, TX Phoenix, AZ Other __________

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.

© Hy-Vee Health 2023

COMPREHENSIVE SUPPORT FOR ALLERGY / IMMUNOLOGY THERAPY

Patient Information

Patient Name: ______________________ **DOB:** ______________________

Required Documentation for Referral Processing and Insurance Approval

Include signed and completed order (MD/prescriber to complete page 1)

Include patient demographic information and insurance information

Include patient's medication list

Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits or contraindications to conventional therapy

Please indicate any tried and failed therapies (if applicable):

Corticosteroids ______________________

Long-acting beta 2 agonist ______________________

Long-acting muscarinic antagonist ______________________

Immunosuppressants (EGPA) ______________________

Asthma – Does the patient have a history of 2 exacerbations requiring a course of oral/systemic corticosteroids, hospitalization or an emergency room visit within a 12-month period? Yes No

Asthma – Does the patient have an ACQ score consistently greater than 1.5 or ACT score consistently less than 120? Yes No

PI – Documentation of recurrent bacterial infections, history of failure to respond to antibiotics, documentation of pre and post pneumonococcal vaccine titers

Include labs and/or test results to support diagnosis **(attach results)**

Does patient have a baseline peripheral blood eosinophil level of ≥150 cells/mcL within the past 6 weeks (asthma and EGPA) or ≥1000 cells/mcL within 4 weeks (HES)? Yes No

FEV1 score (if applicable): ______________________

Serum IgE level – *for asthma and nasal polyps Xolair*

Skin/RAST test – *for asthma Xolair*

Serum immunoglobulins – *for Ig*

Serum creatinine – *for Ig*

CBC w/differential – *for Fasenra, Nucala, Cinqair*

If injection order, is the patient or caregiver not competent or physically unable to administer the product for self-administration? Yes No

Xolair – Patient has Epi pen prescribed

Other Medical Necessity: ______________________

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

HY-VEEHEALTHINFUSION.COM

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.

© Hy-Vee Health 2023