Hy-Vee health™

ANTIBIOTIC
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:** ____________

INSURANCE INFORMATION: Please attach a copy of insurance cards (front and back).

Medical Information

Patient Weight: ________ lbs. (required) **Height:** ________ **Diabetic:** Yes No

Allergies: ____________

Primary Diagnosis: ____________ **ICD-10 Code:** ____________

Home infusion patients, please answer the following:

Has patient previously received this antibiotic? Yes No – If no, can first dose be given in the home Yes No

Arrange for first dose outpatient? Yes No Arrange for nursing? Yes No

Can we send the following: Diphenhydramine 25-50 mg PO or IV PRN allergic reaction (adult)
Epinephrine 1:1000, 0.3 mL IM PRN severe allergic reaction (adult)

*Refer to prescriber orders for peds dosing.

Does the patient have an IV line? Yes No – If no, arrange for PICC/midline? Yes No

Remove PICC/midline at the end of therapy? Yes No

Therapy Order

Acyclovir	Cipro	Kimyrsa	Teflaro
Amikacin	Clindamycin	Levaquin	Tigecycline
Amphotericin B	Cubicin	Merrem	Timentin
Ampicillin/Sulbactam (Unasyn)	Dalvance	Metronidazole (Flagyl)	Tobramycin
Avycaz	Doribax	Mycamine	Tygacil
Cefazolin	Fluconazole	Nafcillin	Vancomycin
Cefepime (Maxipime)	Gentamicin	Orbactiv	Vibativ
Ceftazidime (Fortaz)	Imipenem/Cilastatin (Primaxin)	Oxacillin	Xerava
Ceftriaxone (Rocephin)	Invanz	Piperacillin/Tazobactam (Zosyn)	

Other: ____________ Do not substitute

Dose: ________ mg ________ grams ________ mg/kg

Frequency: Daily Every 12 hours One dose
Every ________ hours Continuous over 24 hours Other: ________

Duration: ________ days ________ weeks **Route:** IV IM Other: ________

Flush orders: NS 1-20 mL pre/post infusion PRN D5W 1-20 mL pre/post infusion PRN
Heparin 10 U/mL per protocol as indicated Heparin 100 U/mL per protocol as indicated

Lab orders: ____________ **Frequency:** Weekly Other: ________

Other orders: ____________ **Required labs to be drawn by:** Hy-Vee Health Prescriber

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:** ________

Service Areas

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

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COMPREHENSIVE SUPPORT FOR ADAKVEO THERAPY

Patient Information

Patient Name: ______________________ **DOB:** ______________________

Required Documentation for Referral Processing & 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 (H&P) to support primary diagnosis

Labs attached

Culture results attached (if applicable)

PICC/Central line placement confirmation (if applicable)

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.

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