

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
Cellulitis MRSA Skin infection/Abscess ICD-10: _____	Cubicin 4 mg/kg IV 6 mg/kg IV Daily for _____ days _____ weeks Orbactiv 1200 mg IV x1 dose Rocephin 1 gm IV 2 gm IV Daily for _____ days _____ weeks Dalvance 1000 mg IV followed 1 week later by 500 mg 750 mg IV followed 1 week later by 375 mg (CrCl<30) 1500 mg IV x1 dose 1125 mg IV x1 dose (CrCl<30)	
Dermatomyositis Dermatopolymyositis Phemphigoid/Pemphigus Other: _____ ICD-10: _____	IVIg orders: _____ mg/kg OR _____ gm/kg IV x _____ day(s) OR divided over _____ day(s) Frequency: Every _____ weeks x1 year OR _____ 1 time dose only Preferred brand: _____ (Hy-Vee Health to choose if not indicated) Additional Ig orders: _____	
CIU ICD-10: _____	Xolair 150 mg Sub-Q every 4 weeks 300 mg Sub-Q every 4 weeks Note: Patient must have an EpiPen in their possession on their appointment date.	
Pemphigus vulgaris ICD-10: _____	Rituximab or rituximab biosimilar as required by patient's insurance Do not substitute. Infuse the following rituximab product: _____ <i>For Hy-Vee Health use only. Brand:</i> _____ Initial dose: 1000 mg IV at days 0 and 15 Maintenance dose: 500 mg IV at month 12 and every 6 months thereafter Other dose: _____ Protocol premedication orders: Solu-Medrol 100 mg IV, Tylenol 1000 mg PO and Benadryl 50 mg PO/IV	
Psoriatic arthritis Psoriasis Plaque psoriasis ICD-10: _____	Infliximab or infliximab biosimilar as required by patient's insurance Do not substitute. Infuse the following infliximab product: _____ <i>For Hy-Vee Health use only. Brand:</i> _____ Dose: _____ mg/kg Frequency: Every _____ weeks OR weeks 0, 2, and 6, then every 8 weeks Simponi aria Initial dose: 2 mg/kg IV at weeks 0 and 4, then every 8 weeks Maintenance dose: 2 mg/kg IV every 8 weeks Stelara 45 mg Sub-Q initially and 4 weeks later, followed by 45 mg every 12 weeks (≤ 100kg) 90 mg Sub-Q initially and 4 weeks later, followed by 90 mg every 12 weeks (>100kg) Maintenance dose: 45 mg Sub-Q every 12 weeks OR 90 mg Sub-Q every 12 weeks Ilumya Initial dose: 100 mg Sub-Q at weeks 0 and 4, then every 12 weeks thereafter Maintenance dose: 100 mg Sub-Q every 12 weeks Cimzia 200 mg Sub-Q every 2 weeks 400 mg Sub-Q every 4 weeks 400 mg Sub-Q every 2 weeks 400 mg Sub-Q at weeks 0, 2 and 4, followed by 200 mg 400 mg every 2 weeks	

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: _____ Yearly TB QFT (optional)

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 _____



COMPREHENSIVE SUPPORT FOR DERMATOLOGY 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 to include any past tried and/or failed therapies, intolerance, benefits or contraindications to conventional therapy

For biologic orders, has the patient had a documented contraindication/intolerance or failed trial of a conventional therapy (i.e., steroids)?

Yes No

If yes, which drug(s)? _____

For biologic orders, does the patient have a contraindication/intolerance or failed trial to any other biologic (i.e., Stelara, Cimzia)?

Yes No

If yes, which drug(s)? _____

Include labs and/or test results to support diagnosis

If applicable – Last known biological therapy: _____ and last date received: _____. If patient is switching to biologic therapies, please perform a washout period of _____ weeks prior to starting ordered biologic therapy.

Other Medical Necessity: _____

Required prescreening (based on drug therapy)

TB screening test completed within 12 months – attach results

Required for: Cimzia, Infliximab, Stelara, Ilumya, Simponi aria

Positive Negative

Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM)

Required for: Cimzia, Infliximab, Rituximab, Simponi

Positive Negative

Baseline creatinine Required for IVIG

*If TB or Hepatitis B results are positive, please provide documentation of treatment or medical clearance, and a negative CXR (TB+).

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

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