Hy-Vee health

INFLIXIMAB
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. Allergies: _____

Diagnosis: ☐ Crohn's disease ☐ Ulcerative colitis ☐ Rheumatoid arthritis ☐ Ankylosing spondylitis

ICD-10: _____ ☐ Psoriasis ☐ Other: _____

Therapy Order

Infliximab: *(choose one)*

☐ Infuse infliximab **OR** infliximab biosimilar as required by patient's insurance
**Preferred product to be determine after benefits investigation (noted below)

☐ Do not substitute. Infuse the following infliximab product: _____

Dose: _____ mg/kg

Frequency: ☐ weeks 0, 2 and 6, then every 8 weeks (initial start) x1 year

☐ Every _____ weeks (maintenance dose) x1 year

☐ Other: _____

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 testing QFT (optional) Required labs to be drawn by: ☐ Hy-Vee Health ☐ Referring Physician

Anaphylactic reaction orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50 mg orally OR IV (adult)
- NS 0.9% 500 mL IV bolus as needed (adult)
- Refer to physician order or institutional protocol for pediatric dosing

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

*For Hy-Vee Health Use Only

Drug/Brand Selection: _____

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 _____

HY-VEEHEALTHINFUSION.COM

COMPREHENSIVE SUPPORT FOR INFLIXIMAB THERAPIES

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
  - ☐ Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID or conventional therapy (i.e., MTX, Leflunomide)?
    - ☐ Yes ☐ No
    - If yes, which drug(s)? _____
  - ☐ Does the patient have a contraindication/intolerance or failed trial to at least 1 biologic (i.e., Humira, Enbrel, Stelara, Cimzia)?
    - ☐ Yes ☐ No
    - If yes, which drug(s)? _____
  - ☐ If psoriasis diagnosis, percent of body surface (BSA) involved: _____ %
- ☐ 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 infliximab.
- ☐ Other Medical Necessity: _____

Required Prescreening

- ☐ **TB screening test completed within 12 months – attach results**
  - ☐ **Positive** ☐ **Negative**
- ☐ **Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) – attach results**
  - ☐ **Positive** ☐ **Negative**

*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.

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