

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	
Iron deficiency anemia Iron deficiency anemia with CKD not on dialysis (ICD-10 Code: _____)	<p>**If the patient has Aetna, Cigna, Humana or UHC, the patient must try and fail Venofer first.**</p> <p>Venofer 200 mg IV – Administer 5 doses over a 14 day period</p> <p>Venofer 200 mg IV weekly x5 dose</p> <p>Injectafer 15 mg/kg IV – Give 2 doses at least 7 days apart, not to exceed 1500 mg (wt <50kg)</p> <p>Injectafer 750 mg IV – Give 2 doses at least 7 days apart, not to exceed 1500 mg (wt ≥50kg)</p> <p>Monoferric 20 mg/kg IV x1 dose (wt <50kg)</p> <p>Monoferric 1000 mg IV x1 dose (wt ≥50kg)</p>	
Chronic gouty arthropathy w/tophus (tophi) Chronic arthropathy w/o mention of tophus (tophi) (ICD-10 Code: _____)	<p>Krystexxa 8 mg IV every 2 weeks</p> <p>Premedication protocol: Benadryl 50 mg IV/PO and Solu-Medrol 125 mg IV</p> <p>Other orders: _____</p> <p>For Hy-Vee Health to dispense the methotrexate, please check appropriate box: Methotrexate 15 mg PO weekly x1 year (begin 4 weeks prior to Krystexxa)</p>	Refills _____ x1 year
X-linked hypophosphatemia (ICD-10 Code: E83.31)	<p>**Max dose 90 mg**</p> <p>Crysvita Adult XLH 1 mg/kg Sub-Q rounded to nearest 10 mg every 4 weeks</p> <p>Crysvita Pediatric XLH 0.8 mg/kg Sub-Q rounded to nearest 10 mg q 2 weeks</p> <p>Other dosage: _____, frequency _____</p>	Refills _____ x1 year
Diagnosis: _____ (ICD-10 Code: _____)	<p>Rituximab IV Dose: 1000 mg 375 mg/m² Other: _____</p> <p>Frequency: 1 time dose Weekly x4 weeks Day 0, repeat dose in 2 weeks Other: _____</p> <p>May substitute biosimilar per insurance. For Hy-Vee Health use – Brand _____</p> <p>Do not substitute. Brand: _____</p> <p>Premedication protocol: Benadryl 50 mg IV/PO and Solu-Medrol 100 mg IV</p>	Refills _____ x1 year
Kidney transplant (ICD-10 Code: _____)	<p>Nulojix _____ mg IV q 4 weeks</p> <p>Other: _____</p>	Refills _____ x1 year
Diagnosis: _____ (ICD-10 Code: _____)	<p>IVIg: _____ mg/kg OR _____ gm/kg IV x _____ day(s) OR divided over _____ day(s)</p> <p>Frequency: Every _____ weeks OR _____</p> <p>(Hy-Vee Health to choose if not indicated) Preferred brand: _____</p> <p>Additional Ig orders: _____</p>	Refills _____ x1 year

Premedication orders: Tylenol 1000 mg 500 mg PO, please choose 1 antihistamine:
Diphenhydramine 25 mg PO/IV 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: _____

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 NEPHROLOGY 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 (attach)

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?

Yes No

If yes, which drug(s)? _____

Include labs and/or test results to support diagnosis

Other medical necessity: _____

Required Information

Baseline serum uric acid and G6PD serum level (Krystexxa)

CBC, iron, transferrin, ferritin, TIBC (iron)

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

Positive Negative

Serum phosphorus (Crysvita)

Nulojix Distribution Program notification (855) 511-6180 – Patient ID# _____

TB screening test completed within 12 months (Nulojix)

Positive Negative

EBV serostatus (Nulojix)

Creatinine (Ig)

*If TB or Hep 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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