Hy-Vee health

OB/GYN
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	
☐ Mild hyperemesis (ICD-10: O21.0) ☐ Hyperemesis w/metobolic disturbance (ICD-10: O21.1) ☐ Other: _____ (ICD-10 Code:_____)	☐ 1 liter ☐ 2 liters D5 .45 NS IV x1 day ☐ 1 liter ☐ 2 liters NS IV x1 day ☐ 1 liter ☐ 2 liters ringers lactate IV x1 day ☐ 1 liter ☐ 2 liters D5/ringers lactate x1 day	☐ **Zofran** 4 mg IVP x1 ☐ **Zofran** 8 mg IVP x1 ☐ May repeat regimen x _____ days
☐ Iron deficiency anemia ☐ Other medical necessity: _____ (ICD-10 Code:_____)	****If the patient has Aetna, Cigna, Humana or UHC, the patient must try and fail Venofer first.**** ☐ **Venofer** 200 mg IV – Administer 5 doses over a 14 day period ☐ **Venofer** 200 mg IV weekly x5 doses ☐ **Injectafer** 15 mg/kg IV – Give 2 doses at least 7 days apart, not to exceed 1500 mg (wt <50kg) ☐ **Injectafer** 750 mg IV – Give 2 doses at least 7 days apart, not to exceed 1500 mg (wt ≥50kg) ☐ **Monoferric** 20 mg/kg IV x1 dose (wt <50kg) ☐ **Monoferric** 1000 mg IV x1 dose (wt ≥50kg)	
☐ Pyelonephritis ☐ Complicated UTI ☐ Other: _____ (ICD-10 Code:_____)	☐ Rocephin 1 gm IV daily x7 days ☐ Rocephin 2 gms IV daily x7 days ☐ Ivanz 1 gm IV daily x7 days ☐ Other: _____	
☐ Migraines ☐ Other: _____ (ICD-10 Code:_____)	☐ Zofran 4 mg IVP x1 ☐ Zofran 8 mg IVP x1 ☐ Reglan 10 mg IV x1 ☐ May repeat migraine regimen x _____ days	☐ Mag sulfate 1 gram IV x1 ☐ Depacon 500 mg IV x1 ☐ DHE 45 1 mg IV x1 — Non-OB patients
☐ Other: _____ (ICD-10 Code:_____)	☐ Other: _____	

Lab orders: _____ **Lab frequency:** _____

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 _____

HY-VEEHEALTHINFUSION.COM

COMPREHENSIVE SUPPORT FOR OB/GYN 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
  - ☐ CBC, Iron, Ferritin, Transferrin, TIBC (for iron orders) – **attach results**
  - ☐ Baseline LFTs (for Depacon orders) – **attach results** **can draw with first infusion if not available*
- ☐ **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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