

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. Patient Height: _____ Allergies: _____

ICD-10: _____ **Diagnosis:** Rheumatoid arthritis, unspecified Wegener's granulomatosis
 Unspecified iridocyclitis Ankylosing spondylitis, unspecified
 Arthropathic psoriasis, unspecified Gout
 Rheumatoid arthritis with rheumatoid factor, unspecified Systemic lupus erythematosus
 Rheumatoid arthritis without rheumatoid factor, unspecified Other: _____

Therapy Order

Drug	Dosing	Refill
Actemra	4 mg/kg IV every 4 weeks for _____ doses, then followed by 8 mg/kg every 4 weeks thereafter 4 mg/kg IV every 4 weeks 8 mg/kg IV every 4 weeks Other dose: _____ mg IV every 4 weeks	
Cimzia	Initial dose: 400 mg subcutaneously at weeks 0, 2 and 4 Maintenance dose: 200 mg subcutaneously Q 2 weeks OR 400 mg subcutaneously Q 4 weeks	
Krystexxa	8 mg IV every 2 weeks	
Immunoglobulin	IV Sub-Q _____ gm/kg x _____ day(s) OR divided over _____ day(s) _____ mg/kg x _____ day(s) OR divided over _____ day(s)	Brand: _____ (Hy-Vee Health to choose if not indicated) Frequency: Every _____ weeks or _____
Orencia	Orencia dose: _____ mg IV Frequency: Every 4 weeks OR weeks 0, 2 and 4, then every 4 weeks thereafter	
Simponi Aria	Initial dose: 2 mg/kg at weeks 0 and 4, then every 8 weeks Maintenance dose: 2 mg/kg every 8 weeks	
Stelara	Initial dose: 45 mg subcutaneously initially, 4 weeks later, followed by 45 mg every 12 weeks 90 mg subcutaneously initially, 4 weeks later, followed by 90 mg every 12 weeks Maintenance dose: 45 mg subcutaneously every 12 weeks Maintenance dose: 90 mg subcutaneously every 12 weeks	
Infliximab	Dose: _____ mg/kg Frequency: Every _____ weeks weeks 0, 2 and 6, then every 8 weeks	May substitute biosimilar per insurance requirement For Hy-Vee Health use. Brand: _____ Do not substitute. Brand: _____
Rituximab	Dose: 1000 mg Other: _____ 375 mg/m ² Frequency: 1 time dose Weekly x4 weeks Day 0, repeat dose in 2 weeks	May substitute biosimilar per insurance requirement For Hy-Vee Health use. Brand: _____ Do not substitute. Brand: _____
Saphnelo	300 mg IV every 4 weeks	

Premedication orders: Tylenol 1000 mg 500 mg PO, please choose 1 antihistamine:
 Diphenhydramine 25-50 mg PO/IV Loratadine 10 mg PO Cetirizine 10 mg PO Quztytir 10 mg IVP

Additional premedications: Solu-Medrol _____ mg IVP Solu-Cortef _____ mg IVP Other: _____

Lab Orders: _____ **Frequency:** Every infusion Other: _____ Yearly TB QFT (optional)

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 _____

Patient Information

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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?

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: Actemra, Cimzia, Infliximab, Stelara, Simponi Aria, Orencia

Positive Negative

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

Required for: Actemra, Cimzia, Infliximab, Rituximab, Simponi Aria

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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