Hy-Vee health
INFUSION CARE

ANTIBIOTIC 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. (required) **Height:** _____ **Diabetic:** ☐ Yes ☐ No

Allergies: _____

Primary Diagnosis: _____ **ICD-10 Code:** _____

Home infusion patients, please answer the following:

Has patient previously received this antibiotic? ☐ Yes ☐ No – If no, can first dose be given in the home ☐ Yes ☐ No

Arrange for first dose outpatient? ☐ Yes ☐ No Arrange for nursing? ☐ Yes ☐ No

Can we send the following: ☐ Diphenhydramine 25-50 mg PO or IV PRN allergic reaction (adult)
☐ Epinephrine 1:1000, 0.3 mL IM PRN severe allergic reaction (adult)
*Refer to prescriber orders for peds dosing.

Does the patient have an IV line? ☐ Yes ☐ No – If no, arrange for PICC/midline? ☐ Yes ☐ No

Remove PICC/midline at the end of therapy? ☐ Yes ☐ No

Therapy Order

☐ Acyclovir	☐ Cipro	☐ Kimyrsa	☐ Teflaro
☐ Amikacin	☐ Clindamycin	☐ Levaquin	☐ Tigecycline
☐ Amphotericin B	☐ Cubicin	☐ Merrem	☐ Timentin
☐ Ampicillin/Sulbactam (Unasyn)	☐ Dalvance	☐ Metronidazole (Flagyl)	☐ Tobramycin
☐ Avycaz	☐ Doribax	☐ Mycamine	☐ Tygacil
☐ Cefazolin	☐ Fluconazole	☐ Nafcillin	☐ Vancomycin
☐ Cefepime (Maxipime)	☐ Gentamicin	☐ Orbactiv	☐ Vibativ
☐ Ceftazidime (Fortaz)	☐ Imipenem/Cilastatin (Primaxin)	☐ Oxacillin	☐ Xerava
☐ Ceftriaxone (Rocephin)	☐ Invanz	☐ Piperacillin/Tazobactam (Zosyn)	

☐ Other: _____ ☐ Do not substitute

Dose: _____ mg _____ grams _____ mg/kg

Frequency: ☐ Daily ☐ Every 12 hours ☐ One dose
☐ Every _____ hours ☐ Continuous over 24 hours ☐ Other: _____

Duration: _____ days _____ weeks **Route:** ☐ IV ☐ IM ☐ Other: _____

Flush orders: ☐ NS 1-20 mL pre/post infusion PRN ☐ D5W 1-20 mL pre/post infusion PRN
☐ Heparin 10 U/mL per protocol as indicated ☐ Heparin 100 U/mL per protocol as indicated

Lab orders: _____ **Frequency:** ☐ Weekly ☐ Other: _____

Other orders: _____ **Required labs to be drawn by:** ☐ Hy-Vee Health ☐ Prescriber

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:** _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX ☐ Phoenix, AZ ☐ Other _____

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COMPREHENSIVE SUPPORT FOR ADAKVEO 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
- ☐ Culture results attached (if applicable)
- ☐ PICC/Central line placement confirmation (if applicable)
- ☐ **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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